CHAPTER 69

AFDC-RELATED MEDICAID MANUAL

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SUBCHAPTER 1. AFDC-RELATED MEDICAID IN NEW JERSEY

10:69-1.1 Background

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public Law 104-193, enacted August 22, 1996, implemented Federal welfare reform. The new Federal law eliminated the Aid to Families with Dependent Children (AFDC) program and created a Temporary Assistance for Needy Families (TANF) block grant for states to provide time-limited cash assistance. New Jersey's block grant program is established as Work First New Jersey (WFNJ) in accordance with the Work First New Jersey Act, P.L. 1997, c.13, c.14, c.37 and c.38. P.L. 104-193 also required that the regulations governing a state's eligibility for AFDC-related Medicaid in effect in the State as of July 16, 1996, must continue to determine eligibility for AFDC-related Medicaid. This chapter is the continuation of the appropriate AFDC-related Medicaid rules.

10:69-1.2 Purpose and scope

The purpose of this chapter is to set forth the policies and procedures necessary for the orderly and equitable provision of AFDC-related Medicaid on a Statewide basis. It is binding on the county boards of social services (CBOSSs) and enforceable by the Division of Medical Assistance and Health Services (DMAHS). Questions of interpretation shall be resolved by the Division of Medical Assistance and Health Services.

10:69-1.3 Administrative organization

(a) The Department of Human Services is the administrative unit of State government which has the responsibility for the Medicaid program and is designated under Federal law as the "single State agency."

(b) The Division of Medical Assistance and Health Services is the administrative unit of the Department responsible for the general policies governing the administration of medical assistance, and for effecting the issuance of rules and administrative bulletins to implement statutory provisions and to coordinate the administration of medical assistance with the Division of Family Development. The Division of Medical Assistance and Health Services provides for the payment of claims, evaluates health services rendered under the program, maintains administrative liaison with the other Departmental divisions, and establishes incapacity under the AFDC-related Medicaid program.

(c) The Division of Medical Assistance and Health Services has local Medicaid District Offices (MDOs) throughout the State. The role of these offices is to act as a liaison with providers of health services; provide information about Medicaid to beneficiaries and members of the community; and provide information about Medicaid to, and cooperate with, appropriate agencies in order to ensure maximum utilization of the services

available through the Medicaid program.

10:69-1.4 AFDC-related Medicaid

(a) The AFDC-related Medicaid program is a State program with Federal participation. It is designed to make payments to providers for medical care and services on behalf of certain individuals whose income is determined to be inadequate to enable them to secure quality medical care at their own expense.

(b) The Aid to Families with Dependent Children-related Medicaid program is composed of three segments:

1. AFDC-C related Medicaid, through which medical assistance is provided for children and their natural or adoptive parents or certain designated relatives with whom they were living, when they are financially eligible and deprived of parental support and care by reason of death, continued absence, or incapacity of one or both parents;
2. AFDC-F related Medicaid, through which medical assistance is provided to families with children when both parents are in the home, neither is incapacitated and the principal earner meets the Federal definition of unemployment; and
3. AFDC-N related Medicaid, through which medical assistance is provided to families with children when both parents are in the home and are not incapacitated but have inadequate income for support of the family.

(c) Information, applications and staff agency personnel shall be available to assist non-English speaking applicants for AFDC-related Medicaid income maintenance programs listed in N.J.A.C. 10:69-1.8. Spanish language program material is routinely prepared by the Division and distributed to county agencies. Minority program materials in languages other than Spanish may be prepared based on knowledge of the population served by programs under the auspices of the Division.

10:69-1.5 Definitions

The following words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise.

"Adequate notice" means notice to a client of the county board of social services (CBOSS) decision or action which must state the nature, effective date, factual and legal basis of the decision or action, and the right to a fair hearing.

"Adjusted gross income" means, in self-employment, the net income as determined by subtracting the cost of producing the income from total gross earnings.

"AFDC" means the former Aid to Families with Dependent Children.

"AFDC-related Medicaid" means medical assistance provided to families who would

otherwise qualify for AFDC or deemed to qualify for AFDC if the program were still in existence.

"Agency" means the county board of social services.

"Applicant" means parent or parent-person who applies for AFDC-related Medicaid and whose application has not been officially acted upon by the CBOSS.

"Application process" means all activity performed by the eligibility staff until there is an official disposition of the application.

"Approved application" means an applicant has been determined to be eligible for AFDC-related Medicaid.

"Authorized representative" means an individual (or organization) whom a client designates orally or in writing to act on his or her behalf, or, in cases of incompetency, the person designated to act for the client.

"Beneficiary" means the family unit of parent(s) or parent-person(s) and child(ren) of eligible age who have been found eligible for AFDC-related Medicaid including any individual who is an eligible member of such family.

"Boarder, roomer, roomer-boarder" means a person, other than a member of an eligible unit, whose acceptance in the household is a business arrangement based upon payment in cash for board, room, or room and board.

"BQC" means the Bureau of Quality Control in the Division of Medical Assistance and Health Services.

"Calculated earned income" means amount of earned income remaining after applicable disregards and deductions have been subtracted from total gross earnings. This is the accountable amount to be used in determining the eligible unit's total income.

"Capacity of a legally responsible relative (LRR) to support" means the amount of contribution to be anticipated from an LRR.

"Caretaker relative" means the legally responsible adult or adults residing with the children for whom the application for presumptive eligibility is being made. This definition is used for application of presumptive eligibility only (see N.J.A.C. 10:69-12).

"Carnegie unit" means the credit given for the successful completion of one year's study in one subject in a secondary school. Four Carnegie units per year represents full

time attendance.

"Case record" means the official file of forms, chronological narrative, correspondence and other documents pertinent to the application and eligibility of client case record. It constitutes a complete record which supports the decisions and actions of the CBOSS on a case.

"Categorical program" means a program established by the Federal Social Security Act for the purpose of enabling a state to furnish assistance to financially eligible individuals or families who meet specific eligibility requirements.

"CBOSS" means the county board of social services.

"CBOSS Director" means the county board of social services Director or staff member to whom he or she has delegated specified responsibility.

"Child born of unmarried parents" means a child born to a mother who is not married to the father of such child.

"Child of eligible age" means a child up to the age of 18 or a child up to the age of 19 if a full-time student in a secondary school, or in the equivalent level of vocational or technical training and reasonably expected to complete the program before reaching age 19.

"Client" means an all inclusive term including an applicant or beneficiary of Medicaid.

"Collateral investigations" means contacts with individuals other than members of the applicant's immediate household made with the knowledge and consent of the applicant(s).

"County board of social services" means the county agency designated to administer the AFDC-related Medicaid program.

"County residence" relates only to identification of the CBOSS charged by law with responsibility for the official receipt, registration and processing of applications, and is not an eligibility requirement and does not limit the opportunity for any person residing in New Jersey to qualify for Medicaid.

"CSP" means Child Support and Paternity Program.

"DDD" means the Division of Developmental Disabilities.

"Denied application" means a determination that, for a specific reason, the applicant is ineligible for AFDC-related Medicaid.

"Dependent child" means an eligible child, living in New Jersey with a parent or other enumerated relative.

"Deprivation" means where death, incapacity or continued absence of one or both natural or adoptive parents causes the loss of parental support.

"Desertion" denotes a willful abandonment of duty in violation of a legal obligation; failure to provide support and maintenance or to perform other duties owed to the family members, thus depriving them of care.

"DFD" means the Division of Family Development.

"Dismissed application" means recognition that eligibility need not be considered further because the applicant moved to another state during the application process or cannot be located, or the application was registered in error.

"Disregards" means the amount of earned income discounted in the AFDC programs according to Federal and/or State regulations.

"Division of Employment Services (DES)" means the office within the State Department of Labor responsible for administration of Unemployment Insurance and Temporary Disability Benefits programs.

"Division of Medical Assistance and Health Services" means office within the State Department of Human Services responsible for supervision of the administration of the AFDC-related Medicaid program.

"DMAHS" means Division of Medical Assistance and Health Services.

"DVRS" means the Division of Vocational and Rehabilitation Services.

"DYFS" means the Division of Youth and Family Services in the Department of Human Services.

"Eligible medical institution" means a facility or specified section thereof certified as an approved institution for the purpose of treating acute illness (private or general hospitals) or providing care for the chronically ill (nursing homes or intermediate care facilities).

"Eligible unit" means those family members who apply for and are eligible to receive AFDC-related Medicaid.

"Emancipated" means a child released from the duty to serve and obey his or her parent(s) and having the right to his or her earnings. Emancipation may be expressed or implied from the circumstances.

"Family size" means, in an LRR's household, those persons identified in N.J.A.C. 10:69-11.3 (members of the eligible unit are not included).

"Financially eligible" means meeting the income standards in this chapter.

"Gross earned income" means the total earnings of members of the eligible unit before applicable disregards and deductions are subtracted.

"Head of household" means the individual who is recognized by other members of the household as having primary responsibility for financial control and direction of the household.

"Incapacity" means physical or mental defect, illness or impairment, supported by competent medical testimony, of such a debilitating nature as to reduce substantially or eliminate the parent's ability to support or care for the otherwise eligible child, which is expected to last for a least 30 days.

"Incompetent (certified)" means certified by a court of law as incompetent.

"Inquiry" means any request for information about assistance programs which is not a request for application.

"Institution in New Jersey" means a total facility, or a designated part thereof, that include the following:

1. Hospital--general or special;
2. Nursing facility (NF);
3. Public psychiatric or tuberculosis hospital;
4. Certified section of State operated institution for the mentally retarded; or
5. Intermediate care facility for the mentally retarded (ICF/MR).

"Institution outside New Jersey" means a public or voluntary medical institution which is licensed, certified or approved by the proper authority of the jurisdiction in which the institution is located, so that the costs of care and services provided therein may be paid. Evidence of such license, certification or approval shall be obtained from the Division of Medical Assistance and Health Services.

"LRR" means legally responsible relative.

"Mandatory payroll deductions" means Federal, State and city withholding taxes; Social Security; unemployment compensation taxes; and garnishments as verified by legal document in possession of the employer.

"MDO" means Medicaid District Office in the Division of Medical Assistance and Health Services.

"Medicaid" means a Federal/State program administered by the Division of Medical Assistance and Health Services providing for payment of claims for and evaluation of health services.

"Medicaid Special" means Medicaid coverage available to any dependent child under 21 or an independent child under age 21, who meets the qualifications at N.J.A.C. 10:69-4.

"Needy person" means a person who lacks sufficient income and resources to maintain the AFDC-related Medicaid level of living.

"New application" means the filing of an application request for AFDC-related Medicaid from an individual/family who has never previously requested AFDC- related Medicaid in any county in the State under that program.

"N.J.A.C." means New Jersey Administrative Code.

"Noneligible person" means a person ineligible for AFDC-related Medicaid either due to age, relationship, or for incurring a penalty of ineligibility.

"Official discharge from an institution" means legal discharge of a patient from the institution in which he or she has been confined.

"Ownership of real or personal property" means any and all rights, title or interest, legal or equitable, to such property.

"Parent-minor" means a parent of a child or children who is himself or herself under the age of 18.

"Parent-person" means certain relatives of a child who, in the absence of a natural or adoptive parent, assume parental responsibility.

"Penalty of ineligibility" means when a member(s) of an eligible unit has incurred a penalty for not complying with program requirement(s) and such member(s) is excluded from the eligible unit.

"Pending application" is a general term for application, reapplication, reopened application, or transfer application prior to official disposition.

"Per capita" means an amount equal to one individual's share of the total (allowance, cost, income, etc.).

"Personal interview" means face-to-face discussion between individuals.

"Policy" means guidelines, limited by and consistent with law, which control CBOSS and DMAHS staff in carrying out AFDC-related Medicaid programs.

"Primary wage earner" means principal earner and shall be referred to as the principal earner in this chapter.

"Principal earner" means the parent who earned the greater amount of income in the 24-month period immediately preceding the month of application for AFDC-F or -N.

"Reapplication" means a written request for AFDC-related Medicaid by an individual who has previously applied for, but never received, AFDC-related Medicaid under that program in any county in the State.

"Recovery" means the process whereby the CBOSS seeks the repayment of AFDC-related Medicaid improperly or properly obtained.

"Redetermination of eligibility" means investigation of all facts and circumstances relating to the beneficiary's application for continuation of AFDC-related Medicaid.

"Referral" means a request from an agency, institution, or individual on behalf of another individual who is interested in applying for AFDC-related Medicaid; or a request from the CBOSS to another agency.

"Registration" means the action of the CBOSS in creating an official record of and assigning a control number to an application.

"Rejected application" means an inclusive term covering applications which have been denied, dismissed, or withdrawn.

"Relatives, legally-responsible" means relatives held to be legally responsible by the

laws of this State, as identified in N.J.A.C. 10:69-3.

"Release without discharge" means an arrangement under which a patient in an institution is, for a special purpose, permitted to reside outside the institution, and includes extended visit and convalescent leave.

"Reopened application" means a written request for Medicaid by an individual who has previously received AFDC-related Medicaid under that program in any county in the State.

"Request for local administrative review" means any clear expression (oral or written, by letter or otherwise) by a client or his or her authorized representative that he or she wishes to present his or her case in a proceeding before the CBOSS director or his or her delegated representative. This is not to be confused with a request for a fair hearing.

"Resident" means a person who is living in the State for other than a temporary purpose and who has no intention of moving from the State.

"Retirement, Survivors and Disability Insurance (RSDI)" means the Federal program administered by the Social Security Administration (SSA) which provides protection to workers and their families against loss or stoppage of earnings resulting from retirement at age 62 or older, death or disability.

"Return to state of origin" designates the desire of a family who has resided in New Jersey for a relatively short period to return to the state from which it came.

"RSDI" means Retirement, Survivors and Disability Insurance.

"Social Security payment" means RSDI benefit.

"Sponsoring adult" means an individual 18 or older, including the applicant or the adult with whom the applicant resides, who may assist in making an application for presumptive eligibility. This definition is used for the application presumptive eligibility only (see N.J.A.C. 10:69-12).

"Spouse" means a husband or wife of a specified individual.

"SSA" means the Social Security Administration.

"SSI" means the Federal Supplemental Security Income Program, including State

supplemental payments administered through this program for aged, blind or disabled of any age.

"State institution" means any institutional facility for the mentally ill or retarded, penal institution or veteran's hospital under the jurisdiction of the State of New Jersey.

"Total income" means the sum of all recognized income of the eligible unit, including unearned and calculated earned income.

"Transfer application" means a request for AFDC-related Medicaid for an individual who is presently receiving AFDC-related Medicaid under the same program in another county within the State.

"Vendor payment" means a check drawn to the order of a person or facility for providing goods or services to or for the client, representing payment for such goods or services.

"Withdrawn application" means an oral or written request by an applicant that the CBOSS terminate its activity on his or her application.

END OF SUBCHAPTER 1

SUBCHAPTER 2. THE APPLICATION PROCESS

10:69-2.1 General provisions

(a) Any person who believes he or she and his or her children are eligible for AFDC-related Medicaid shall be given the opportunity to apply without delay. Applicants shall be informed by the county board of social services about the eligibility requirements and their rights and obligations in applying for and receiving assistance. The decision to apply rests with the applicant. The applicant has the right to withdraw the application before eligibility or ineligibility has been determined.

(b) County board of social services staff shall move with all reasonable speed in accepting, processing and recommending action on applications for assistance. If an applicant is eligible, an AFDC-related Medicaid Eligibility Card shall be issued as eligibility is established. The agency's standards of promptness for acting on applications or redetermining eligibility shall not be a basis for delay in granting AFDC-related Medicaid.

(c) This subchapter describes briefly the steps followed by the eligibility determination worker in determining an applicant's eligibility to receive AFDC- related Medicaid.

10:69-2.2 Provisions governing the initial contact

(a) The application process begins with an individual's initial contact with the agency and ends with a decision by the county board of social services as to the eligibility for Aid to Families with Dependent Children related Medicaid (AFDC-related Medicaid). Both the applicant and the eligibility worker have an affirmative responsibility in verifying and documenting eligibility.

(b) Initial contact may be an inquiry, a referral or an application:

1. Inquiry means any request for information about medical assistance programs, which is not a request for an application. A record is necessary only when the inquiry requires follow-up action.
2. Referral means a request from a public or private agency or individual for medical assistance on behalf of another individual. All referrals shall be recorded with appropriate facts, and the disposition noted.
3. Application means a written request for AFDC-related Medicaid by natural or adoptive parent(s), parent-person(s), parent-minor, or responsible person acting on his or her behalf.

(c) There are five types of application:

1. A written request for medical assistance by an individual who has never previously applied under that program in any county in the State;
2. A written request for medical assistance by an individual who has previously

applied for, but never received, assistance under that program in any county in the State;

3. A written request for medical assistance by a individual who has previously received assistance under that program in any county in the State, that is, a reopened application;

4. A written request for medical assistance from an individual who is presently receiving AFDC-related Medicaid under the same program in another county in the State; and

5. AFDC-related Medicaid applicants may be eligible for retroactive Medicaid benefits. The eligibility worker shall ask if the family has unpaid medical bills from the three months prior to the month of application and will provide the applicant with appropriate forms.

10:69-2.3 Purpose and scope of first contact

(a) The responsibility of the agency during the initial contact shall include, but not be limited, to:

1. Determining and explaining the medical assistance program for which the client may be eligible and informing the client how and where to apply;

2. Advising individual of general requirements of the application process, for example, the necessity of contacting certain relatives and of certain other collateral contacts with an explanation of the right of the applicant to confidentiality and to be primary source of information. The application form includes a blanket consent statement. The client should be informed that he or she is consenting to have the county board of social services (CBOSS) contact others by signing this form. The applicant is also required to sign a waiver allowing the CBOSS to obtain State income tax information. The eligibility worker shall specifically advise each applicant that by signing the waiver he or she is granting such an authorization. In addition to such oral explanations, the individual shall be provided with the pamphlet, Medicaid Rights and Responsibilities;

3. Advising individual that Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973 prohibit discrimination in determining eligibility for AFDC-related Medicaid;

4. Determining whether the individual does indeed wish to apply with full understanding of the need to verify essential eligibility factors and the requirement for a personal interview;

5. Taking the application without delay; and

6. Advising a pregnant woman that she may make application for New Jersey Care ... Special Medicaid Programs.

10:69-2.4 Completion of forms

(a) The applicant will be fully assisted by the eligibility worker or by any person of his or her choice in completing the Application and Affidavit for AFDC-related Medicaid (PA-1J). Form PA-1J is used to apply for AFDC-related Medicaid.

(b) The applicant's signature(s) and the date of application are required. The PA-1J requires three signatures of the applicant(s). In addition to the first page and the affidavit, the applicant(s), with the exception of non-needy parent-persons who do not request medical assistance for them, shall sign a release which authorizes the CBOSS to obtain State income tax information.

1. In AFDC-C-related Medicaid, a written application and the authorization to obtain State income tax information is to be signed under oath by the applicant himself or herself or, when the applicant is incapacitated or alleged incompetent (N.J.A.C. 10:69-3.12(b)), by someone acting responsibly for him or her.

i. When both parents are in the home, both shall be required to sign the application and the authorization to obtain State income tax information except that if a parent is unavailable to sign the application and the authorization to obtain State income tax information for reasons beyond the family's control, one signature will suffice. In that event, the non- signatory parent shall be required to annex his or her signature as promptly as he or she is available for such purposes.

ii. A non-needy parent-person who does not make application for AFDC- related Medicaid for himself or herself is required to sign the application but is not required to sign the authorization to obtain State income tax information. This exception does not apply to natural or adoptive parents.

2. In AFDC-F and -N, a written application and the authorization to obtain State income tax information shall be completed and signed by both parents. If one parent is unavailable to sign the application, see (b)1i above.

(c) The eligibility worker shall review the application to make sure it is complete and to check any apparent discrepancy or confusion in the information provided by the applicant with him or her, arriving at a resolution if possible in order to process the application.

(d) The application shall be registered immediately and a number assigned in the series designed for the applicable program. A reapplication or reopened application shall be assigned its previous number if within the same county.

10:69-2.5 Registration of applications

(a) Official registration of an application shall include:

1. Entry in an application register under appropriate classification; and
2. Assignment of a registration number.

(b) Registration shall be completed on the same day application is made, or, if application is made outside the CBOSS office, registration shall be completed within three working days.

10:69-2.6 Eligibility for Aid to Families with Dependent Children (AFDC)- related Medicaid

(a) Eligibility for AFDC-related Medicaid is based upon certain criteria such as age, relationship, residence in the State, alien status and upon other criteria relevant to each segment.

(b) Eligibility for the AFDC-C-related Medicaid segment is based on financial need and deprivation of parental support and care by reason of mental or physical incapacity, absence or death of one or both parents.

(c) Eligibility for the AFDC-F segment is based on financial need when both parents are in the home, neither is incapacitated and the parent who is the principal earner meets the Federal definition of unemployment.

(d) Eligibility for the AFDC-N-related Medicaid segment shall be determined when both parents are present in the home and are not incapacitated, there is insufficient income for support of the family and the family does not meet the Federal criteria for the AFDC-F segment.

(e) All AFDC-F and -N clients shall be advised that their eligibility for these segments is based on the fact that there are two parents who are not incapacitated in the home and that, if a parent dies, becomes incapacitated or leaves the household, this fact should be brought to the attention of their eligibility worker so that an application for AFDC-C-related Medicaid and/or referral to SSI can be considered.

(f) Income standards for persons eligible under the AFDC-C-related Medicaid, - F-related Medicaid and -N-related Medicaid appear in Schedule II or III, as appropriate, at N.J.A.C. 10:69-10.3.

10:69-2.7 Financial need

The eligibility worker shall determine financial eligibility (need) of the eligible family members by Form 105, if appropriate, in accordance with this subchapter.

10:69-2.8 Eligibility factors other than need

(a) In verifying eligibility, the eligibility worker shall take whatever action is necessary to assure that all relevant documentation is promptly obtained. The eligibility worker shall assist in obtaining verification documentation if the applicant requests help. The applicant shall cooperate fully consistent with his or her rights including confidentiality and consent.

(b) The eligibility worker shall explain to the applicant that children up to the age of 18 and children up to the age of 19 if they are full-time students in a secondary school, or

in the equivalent level of vocational or technical training, and reasonably expected to complete the program before reaching age 19 are eligible for AFDC-related Medicaid. Program completion is defined as the day of ceremonial graduation.

(c) The relationship between adoptive parent and child(ren) in AFDC-related Medicaid is as follows:

1. The eligibility worker shall explain to the applicant that in order to apply for AFDC-related Medicaid, he or she shall be either the natural or adoptive parent or eligible to serve as a parent-person of the eligible child(ren). An applicant who is a parent-person has the option of applying either for the child(ren) or him or herself as a needy parent-person, or for the child(ren) only. The advantages and disadvantages of each option shall be thoroughly discussed.

2. The eligibility worker shall explain that for AFDC-F and -N segments the child(ren) shall be natural or adoptive to the two parents who are applying.

3. If not eligible for AFDC-related Medicaid, eligibility for any Medicaid program shall be explored.

(d) Rules concerning Social Security numbers are as follows:

1. The AFDC-related Medicaid applicant shall supply the CBOSS with the Social Security number of each member of the eligible unit or apply for a Social Security number for any such person who does not already have one (see (d)3 and 5 below).

2. The eligibility worker shall record, in the appropriate spaces on FAMIS Form 105 and Form PA-1J (Application and Affidavit for AFDC-Medicaid related), the Social Security number of each person who is included in the AFDC-related Medicaid case.

3. The CBOSS shall obtain a supply of Social Security Form SS-5, sufficient to accommodate all AFDC-related Medicaid applicants and eligible individuals that do not already have Social Security numbers. Upon application for AFDC- related Medicaid, the applicant shall be required to sign as many SS-5 forms as needed for the eligible family. The eligibility worker shall complete Form SS-5 on the basis of information provided by the applicant. Completed forms shall be forwarded to the county's respective Social Security Administration District Office (SSA/DO). A copy of the SS-5 form shall be retained in the case record, and a copy given to the client if so requested.

i. The eligibility worker shall record in the case record the date upon which Form SS-5 was prepared.

ii. If any applicant refuses to provide or apply for the appropriate Social Security number(s), the CBOSS shall declare such person ineligible for AFDC- related Medicaid benefits. The eligibility of that individual shall be terminated in accordance with N.J.A.C. 10:69-2.15.

(1) For a "newborn" child, whose birth certificate may not be readily available, the completion time for the SS-5 is extended to the first day of the second month after the birth of the child.

(2) A signed and certified hospital document may be accepted in lieu of a birth

certificate, provided that it contains the same information that would appear on a birth certificate, that is, child's name, date of birth, place of birth, mother's name, mother's residence, and father's name.

iii. AFDC-related Medicaid applicants who are legal residents of the United States in accordance with the provisions of the U.S. Immigration and Naturalization Service (INS), but not United States citizens, shall have Form PA-55, County Board of Social Services Alien Referral to Social Security (SSA) District Office for Social Security Number Application, processed at the SSA/DO in order to be enumerated.

(1) For enumeration purposes, not all U.S. born individuals are U.S. citizens. These individuals may include former U.S. citizens who are now citizens of another country. Additionally, children of foreign diplomats or other temporary aliens who are born in the U.S. while their parents are in the U.S. are considered citizens of the parents' home country. Such individuals shall not be referred to the SSA/DO unless the individual is a legal U.S. resident as stated above.

(2) Form PA-55 is to be used to refer legal residents of the United States as determined by the Immigration and Naturalization Service, who are not U.S. citizens, to the SSA/DO. Liaisons in the SSA/DO have been instructed to return the bottom portion of that form to the specified CBOSS. For quality control purposes, the bottom portion of Form PA-55 is to be filed in the case record and shall serve as acceptable documentation that the individual has applied for a Social Security number.

(3) Each CBOSS is to create a tickler file to monitor the flow of referral forms (PA-55s) and receipts of acknowledgment (bottom portions of Form PA- 55). Immediately upon receipt of such acknowledgment, CBOSSs shall input the filing date of the SS-5 form on the 105 form, thereby providing tracking for the issuance of Social Security numbers, and file the acknowledgment in the case record.

4. Procedures for verifying Social Security numbers are as follows:

i. The CBOSS shall verify the Social Security numbers (SSNs) provided by the eligible family with the Social Security Administration (SSA) by submitting them through FAMIS. Benefits shall not be denied, delayed or terminated for an otherwise eligible family pending SSN verification. Once the SSNs have been verified, the CBOSS shall make a permanent annotation to the case file to prevent unnecessary reverification of the SSN in the future.

5. AFDC-related Medicaid benefits shall not be denied, delayed, or terminated pending issuance or verification of a Social Security number so long as the applicant/beneficiary has complied with the provisions of (d)1 through 4 above.

6. Every applicant for and recipient of Medicaid benefits is required to furnish a valid Social Security number to the CBOSS as a condition of eligibility for Medicaid. Any applicant or recipient who does not already have a Social Security number shall be required to apply for same. In addition, (d)2 through 5 above shall apply to Medicaid recipients.

(e) Rules concerning enumeration at birth are as follows:

1. Participating hospitals have entered into an agreement with the New Jersey Department of Health and Senior Services, Bureau of Vital Statistics, to initiate the enumeration process for newborns while the parent is in the hospital at time of the birth. This process is undertaken through a program implemented by SSA entitled "Hospital Enumeration at Birth Project." This process is for the convenience of the parent and is optional.

2. If the service is available at the hospital and the parent elects to apply, the parent is given Form SSA-2853/0P4, "Message From Social Security," that bears the name of the newborn for whom SSN application has been made and the dated signature of an authorized hospital official.

3. If Form SSA-2853/0P4 contains the identifying information in (e)2 above, it serves as satisfactory verification that the family has applied for a SSN on behalf of the newborn for AFDC-related Medicaid purposes provided that other documentation is available to connect the child to the parent.

4. In instances of "enumeration at birth," the CBOSS worker shall not need to complete Form SS-5, "Application for a Social Security Number Card," for the newborn. Block QM/92 on FAMIS Form 105B shall be completed by utilizing the "888" coding option for the infant in such situations.

5. Parents who elect to enumerate their newborn child(ren) through this process are required to furnish the assigned SSN to the CBOSS when it is received. The CBOSS shall, however, request proof of receipt of the SSN after six months from the child's birth have lapsed or at time of the beneficiary's next redetermination, whichever occurs first. If a SSN has not been assigned to the newborn at that time, then the CBOSS shall complete the SS-5 form for such newborn.

6. If the family is unable to provide Form SSA-2853/0P4, then the child shall be enumerated by the CBOSS through completion of an SS-5 following current application procedures.

7. CBOSSs shall not contact hospitals to verify that a child was enumerated through those facilities.

10:69-2.9 Deprivation of parental support in AFDC-C related Medicaid

(a) Deprivation under AFDC-C-related Medicaid can result from death, incapacity or continued absence of one or both natural or adoptive parents.

(b) The eligibility worker shall inform the applicant of the need to prove the death of the eligible child(ren)'s parent(s) and of the sources available for such documentation (see N.J.A.C. 10:69-3.3).

(c) Physical or mental incapacity of a parent shall be deemed to exist when both parents are in the home and one has a physical or mental defect, illness or impairment. The incapacity shall be supported by competent medical testimony and must be of such a nature as to reduce substantially or eliminate the parent's ability to support or care for

the eligible child and be expected to last for at least 30 days:

1. Evidence of incapacity without need for further development includes:

i. The applicant is receiving benefits not due to age alone under the Supplemental Security Income program (SSI) administered by the Social Security Administration (SSA);

ii. The applicant is receiving Social Security disability insurance benefits as the Federal RSDI program administered by the Social Security Administration; or

iii. The applicant is receiving inpatient care in a medical facility and the attending physician indicates in writing that such care shall be required for at least 30 days.

2. If the applicant claims to be in immediate need and none of the factors in (c)1 above exist, he or she shall be evaluated for AFDC-F or -N.

3. If the applicant has been receiving AFDC-related Medicaid under the AFDC- F or -N segment and incapacity is found not to exist, the CBOSS will so notify the applicant promptly of the denial of the application as to incapacity. (See N.J.A.C 10:69-7.1(1).) While the notice will show no grant change as a result of the denial, fair hearing rights nonetheless apply.

4. To establish eligibility for persons not covered by (c)1 above, see N.J.A.C. 10:69-3.

5. Where appropriate, the eligibility worker shall review with the applicant the desirability of applying for SSI. The eligibility worker shall explain to the applicant that if he or she decides to apply he or she shall be required to sign Forms PA-30 and PA-30A.

(d) Continued absence of the parent from the home constitutes deprivation of parental support or care. Absence shall be considered continued when it interrupts or terminates the parent's functioning as a provider of maintenance, physical care, or guidance for the child; and the known or indefinite duration of the absence precludes the parent's performance of his or her function in planning for the present support or care of the child. If these conditions exist, the parent may be absent for any reason, and he or she may have left only recently or sometime previously.

1. When information is received that an AFDC-related Medicaid beneficiary and his or her children are "living with" or being "frequently visited" by the allegedly absent parent of one or more of the children, the CBOSS shall immediately commence a comprehensive investigation of the family situation. Such investigation shall include:

i. Checking with appropriate authorities, for example, the Division of Motor Vehicles, the Postal Service, utility and telephone companies, employers and landlords, to ascertain whether the allegedly absent parent's address is the same as the beneficiary's address;

ii. Obtaining information from collateral sources to determine whether the parent is living at the beneficiary's address, or, if he or she only visits, how often and for how long. (Affidavits of these circumstances or, more importantly, agreements to testify, if necessary, should be obtained.);

iii. Observing the family home (on more than one occasion);

iv. Interviewing both the AFDC-related Medicaid beneficiary and the allegedly absent parent as to the status of their living arrangements, the frequency, duration, and nature of his or her visits to the family home, the present financial arrangements between them, confronting them with the information previously obtained from independent sources, and permitting them an opportunity to admit, deny, contradict or explain any or all of it; and

v. Following up all leads obtained during the interview, to confirm or disprove assertions made during the interview.

2. When the investigation is completed, the CBOSS shall determine whether the parent is continually absent. If it is determined that the parent is residing with the eligible unit, such parent is not to be considered continually absent. If it has been determined that the parent is not residing with the eligible unit, in order to establish that such parent is not to be considered continually absent, evidence must exist of the parent's provision of three parental functions: maintenance, physical care, and guidance to the child(ren). Unless all three parental functions are present, the "absent" parent shall be considered continually absent. Evidence supporting the determination of continued absence shall be fully documented in the case record.

3. If the CBOSS is convinced that the parent is not absent and the family is no longer eligible for AFDC-C-related Medicaid based on deprivation of parental support or care, the CBOSS shall terminate AFDC-related Medicaid. The family shall be evaluated for eligibility for AFDC-related Medicaid for -N or any other Medicaid program before termination. If termination is necessary, the adverse action notice shall give as the reason for the action that the "absent" parent is either living in the home or that his or her presence in the home is such that he or she can no longer be considered to be continually absent therefrom, and cite the appropriate regulations.

(e) When continued absence as defined in (d) above exists, eligibility for AFDC-F or -N-related Medicaid ceases. The family shall be evaluated for AFDC- C-related Medicaid.

1. In situations where the parent is to be incarcerated, hospitalized, institutionalized or incapacitated for a period beyond 30 days, eligibility for AFDC-F or -N-related Medicaid ceases. The remaining members of the family shall be evaluated for AFDC-C-related Medicaid.

10:69-2.10 Ineligible family members

(a) In addition to those persons who are already not considered to be members of the eligible unit, the following persons shall also not be eligible for Medicaid and shall not be considered to be members of the eligible unit:

1. A person who is fleeing to avoid prosecution, custody or confinement after conviction, under the laws of the jurisdiction from which the person has fled, for a crime or an attempt to commit a crime which is a felony or a high misdemeanor under the laws of the jurisdiction from which the person has fled; or, is violating a condition of probation

or parole imposed under Federal or State law;

2. A person found to have willfully and knowingly fraudulently misrepresented his or her residence in order to obtain means-tested public benefits in two or more states or jurisdictions, shall be ineligible for benefits for a period of 10 years from the date of conviction in a Federal or state court; or

3. Other aliens who are not eligible aliens as defined in N.J.A.C. 10:69- 3.10.

10:69-2.11 Residence requirement

An applicant for or beneficiary of AFDC-related Medicaid shall reside in New Jersey. Application should be made to CBOSS in county of residence even though temporary.

10:69-2.12 Support from relatives

(a) The eligibility worker shall explain to applicant(s) that certain relatives must be contacted and evaluated to determine what capacity, if any, they have to contribute to the family's support. (See N.J.A.C. 10:69-3.35 for enumeration of relatives responsible in each program.) Eligibility for AFDC-related Medicaid shall not be delayed pending evaluation of legally responsible relatives.

(b) Applicants shall be advised that their entitlement to AFDC-related Medicaid shall not be jeopardized by the unwillingness of legally responsible relatives to provide support.

10:69-2.13 Repayment (all segments)

The eligibility worker shall determine from the applicant whether there is a pending claim against any individual, group or agency on behalf of any member of the eligible unit. If such a non-exempt claim does exist, the applicant shall be advised that the completion of the application form authorizes the CBOSS or the Division of Medical Assistance and Health Services to seek recovery of paid medical expenses from any recovery received for medical expenses for treatment of a medical condition.

10:69-2.14 Administrative action on application

The eligibility worker shall review all appropriate forms for completeness and accuracy, and give them to his or her supervisor. The supervisor shall examine the forms for consistency of applicant's statements, completion of all necessary information and correct income computations. If acceptable, the supervisor shall indicate his or her approval by signing. If not acceptable, the forms shall be returned to the eligibility worker for correction.

10:69-2.15 Notice of approval, disapproval and pending status and other information to client

(a) If immediate need is not apparent and a decision of approval or disapproval is not reached within 30 days of application, the CBOSS shall notify the applicant in writing of

this fact and the reason for the delay. If the lack of decision is due to circumstances within the control and knowledge of the applicant, the county board of social services shall remind the applicant of the steps he or she must take to enable the county board of social services to make a decision. This notice shall include a sentence in Spanish cautioning the client that it relates to his or her eligibility for AFDC- related Medicaid and if he or she does not understand the notice he or she should contact the CBOSS.

(b) When a decision is reached, the applicant shall be notified in writing of this decision (approved or disapproved).

(c) If the application is denied, the notice of disapproval shall meet the requirements in N.J.A.C. 10:69-6. In addition, for an applicant whose application has been denied for any reason other than death, the notification shall include:

1. An explicit statement of the reason for ineligibility;
2. A copy of the document entitled "Fair Hearings in the Aid to Families with Dependent Children Program";
3. Advice concerning the family's right to reapply whenever they believe that their circumstances have changed such that the stated reasons for ineligibility no longer exist; and
4. Information about the food stamp program and other potentially available services.

(d) If the application is approved, the client shall be advised in writing:

1. Of the effective date of Medicaid eligibility;
2. That an advance statement shall be sent at least 10 calendar days prior to implementation of any adverse decision affecting future eligibility;
3. Of the client's right to a fair hearing;
4. Of the client's rights and responsibilities under the program for which he or she has been approved (see N.J.A.C. 10:69-2.2(a)3 and 2.3(a));
5. Of his or her obligation to report all relevant changes in circumstances, including but not limited to, family size, income, employment, and change in parent-person status;
6. Of the use of the Medicaid Eligibility Card; and
7. That he or she may qualify for a number of additional services which the eligibility worker will describe briefly and explain where to apply for these services.

(e) Notification to a beneficiary whose application has been approved following change of residence from another county shall include a statement that:

1. The beneficiary has been found to be a resident of this county for purposes of Medicaid coverage; and
2. Future determination of eligibility will be made by this county board of social services (CBOSS) rather than by the CBOSS of the county of previous residence.

(f) When the coverage is based on an earnings projection (see N.J.A.C. 10:69-11.14),

a notice shall be sent advising the client that the coverage for the next month will be terminated unless he or she provides wage verification as required. Such notice shall specify the date by which the verification must be received.

(g) Clients shall also be advised in writing that if he or she is dissatisfied with any action or inaction of the county board of social services, he or she may request a hearing. He or she shall be informed of the steps that are to be followed in making such a request in accordance with the requirements in N.J.A.C. 10:69-6.

(h) A client shall be provided a copy of the written application with any attachments upon request.

(i) In any case initially referred by, or known to be receiving assistance or service from, a public health or welfare agency, social service, legal services or other interested agencies, notice of disposition of the case or any aspect in which that organization has been involved shall be sent to such agency with the consent of the client in the following manner:

1. If, after thorough discussion of the medical coverage potentially available and the application requirements, the person definitely declines to apply, the interested agency shall be promptly informed.
2. If the person applies and the application is approved, the interested agency shall be notified as promptly as possible, including the date of Medicaid eligibility.
3. If the person applies and the application is denied, dismissed or withdrawn, the agency shall be promptly informed.
4. The interested agency shall be kept informed of any developments in a case so long as the issue involved is the same or related to the issue about which the agency has expressed interest unless the client withdraws his or her consent.

10:69-2.16 Withdrawal

(a) The agency shall officially recognize the applicant's action through written notification within five working days of the applicant's request for withdrawal.

(b) This notification shall include a statement that the applicant's decision has been recognized and recorded by the agency, that no further action is being taken on his or her application, and a reminder that he or she has the right to reapply at any time.

10:69-2.17 Dismissal of application when client cannot be located

When it is necessary to dismiss an application because an applicant cannot be located, a notice shall be sent to the person's last known address.

10:69-2.18 Verification

(a) Verification of facts essential to eligibility is required in all segments of the AFDC-related Medicaid program (see N.J.A.C. 10:69-3.2 through 3.7). The eligibility worker shall verify all income.

1. The CBOSS shall try to verify all necessary information within the required time but shall not penalize the client if the CBOSS, through no fault of the client, is unable to obtain documentation.

(b) The CBOSS shall verify the age of all children for whom application is made and their relationship to the natural or adoptive parent(s) or parent- person(s) with whom they live. (See N.J.A.C. 10:69-3.2 through 3.7.)

(c) The CBOSS shall verify the deprivation factor in AFDC-C related Medicaid.

1. The death of the parent(s) shall be verified.
2. Incapacity shall be validated through the medical review team's action expressed in Form PA-8.
3. Continued absence shall be verified in accordance with criteria in N.J.A.C. 10:69-3.

(d) The CBOSS shall verify school attendance in a school, college, training or vocational program of dependent children ages 16 to 19 at the time of application as an eligibility criterion of AFDC-related Medicaid (see N.J.A.C. 10:69-10.5(a) and 10.9).

(e) The CBOSS shall verify the client's county of residence, whether temporary or permanent. (See N.J.A.C. 10:69-3.29.)

(f) Earnings may be verified from voucher records or statements in writing submitted by the employed person, subject to additional verification as required by this chapter.

10:69-2.19 Use of PA-1C as an application request

(a) Individuals who were admitted to a hospital and were subsequently referred to the CBOSS through the use of Form PA-1C, AFDC-related Medicaid Inquiry, may be eligible for AFDC-related Medicaid benefits from the date the PA-1C was completed, provided:

1. Such individual was an inpatient at the time the referral was made;
2. Except for good cause, including, but not limited to, hospitalizations lasting for three or more months, the homebound status of the applicant, the CBOSS was unable to schedule a timely application appointment, or the hospital failed to inform the applicant to apply at the CBOSS, the individual applies for AFDC-related Medicaid benefits within three months after the referral is made.

i. If the CBOSS determines that the individual had good cause for not applying within three months, an extension may be granted for an additional three months.

ii. Newborns of eligible women are deemed to have applied and shall be added to the Medicaid case, effective the date of birth, upon receipt of a valid Form PA-1C.

END OF SUBCHAPTER 2

SUBCHAPTER 3. ESTABLISHING PROGRAM ELIGIBILITY IN AFDC-RELATED MEDICAID

10:69-3.1 Establishing eligibility for AFDC-related Medicaid

(a) This subchapter presents in detail the program eligibility factors that must be considered in making determinations related to the AFDC-C, -F and -N segments.

(b) A decision regarding eligibility shall be made within 30 days of application.

10:69-3.2 Documentation and recording of program eligibility requirements

Fundamental to the establishment of eligibility for AFDC-related Medicaid is the documentation of eligibility requirements.

10:69-3.3 Sources of evidence regarding eligibility

(a) Applicants and beneficiaries are in all instances the primary source of information about themselves and their families. It is the responsibility of the agency to determine eligibility and, as necessary, to secure verification from secondary sources. Such verification information shall be limited to those facts that are essential to establish eligibility and shall be obtained only with the consent of the client. It shall be explained to the client that verification is necessary and lack of consent to obtain it shall make processing of the application eligibility impossible.

(b) The client's statements regarding his or her eligibility are evidence. For purposes of AFDC-related Medicaid, the client's statements must be consistent and certain facts must be documented. The applicant shall be informed that the CBOSS needs to document the facts regarding certain eligibility criteria and that this process shall include contacting collateral sources as necessary:

1. Public records are preferred evidence and investigation of these sources shall be exhausted before other sources are used.
2. Sources of collateral evidence to establish eligibility include, but are not limited to, the following: birth, death and marriage certificates, church records, immigration and naturalization papers, census records, school records, military service records, court records, employment records, records of public or private welfare agencies, voting records, medical records, personal records, and affidavits from knowledgeable persons.

(c) Only evidence to corroborate facts essential to eligibility shall be sought. In determining the relative validity of the sources of evidence in (b), the agency should bear in mind the type and source of document.

(d) Affidavits shall be used only when other sources have failed or have produced inconclusive data. Documentation obtained in this manner shall be taken under oath

from a person who has factual knowledge of the relevant circumstances. The affidavit shall show the circumstances under which this person has known the applicant as well as the factual basis of his or her statements relating to the applicable eligibility requirements.

(e) While it is usually desirable to obtain evidence in written form, personal inspection of records by the agency personnel, where permission can be secured, is an acceptable practice and is often quicker and simpler. (See also N.J.A.C. 10:69-3.5.)

10:69-3.4 Verification of income

(a) All beneficiaries of AFDC-related Medicaid must meet the criteria for financial need.

(b) Earned and unearned income verification is as follows:

1. The eligibility worker shall verify, either through examination of pay stubs or with the client's employer, the amount of gross earned income.
2. All unearned income shall be verified by examination of benefit check or by contact with the company or agency granting such benefit. Social Security benefit information verification may be accomplished through the Automated Benefit Information Exchange (ABIE)/ Beneficiary and Earnings Data Exchange (BENDEX) and/or State Verification and Exchange System (SVES) (see N.J.A.C. 10:69-8.2 concerning SVES).
3. Previous sources of support shall be explored with the applicant.
4. Legally responsible relatives shall be contacted for evaluation of their capacity to support (see N.J.A.C. 10:69-5.9).

10:69-3.5 Recording of documentation

All information, written or oral, including sources and methods of documentation, shall be recorded on Form PA-1J, Application and Affidavit for AFDC-related Medicaid and included in the case record. See N.J.A.C. 10:69- 7.3 concerning documentation procedures.

10:69-3.6 Issuance of summons or subpoena

(a) When all other means of determining facts and circumstances concerning an application for assistance has been exhausted, the county board of social services director may:

1. Issue a subpoena to a third party in the State who has necessary and relevant information and require that pertinent records and other documents be produced for examination; and
2. Administer oaths for the purpose of such examinations.

(b) Action for contempt of court may be initiated when such person fails to obey a subpoena issued by the county board of social services director or to testify to facts and circumstances pertinent to the application for assistance.

(c) The refusal of such person to cooperate shall not disqualify applicant.

10:69-3.7 Eligible unit

(a) The eligible unit shall be comprised of those family members who apply for and are eligible to receive AFDC-related Medicaid. It shall include one or more eligible children unless such child is a beneficiary of SSI or is excluded from the eligible unit in accordance with (c) below.

1. The eligible unit for AFDC-C or -F shall include any blood-related or adoptive brothers and sisters living in the same household and who are otherwise eligible for AFDC-C or -F. This requirement does not apply to stepbrothers or stepsisters.

(b) When a beneficiary of SSI payments is a family member, he or she shall not be included in the eligible unit.

1. When all eligibility factors are present in a two-person family, the individual not receiving SSI benefits shall comprise an eligible unit of one; this applies to a parent as well as to a child; thus, the only eligible individual may be the parent or parent-person, and the appropriate AFDC- related Medicaid eligibility shall be for that individual only.

2. There may be cases in which the beneficiary count shall be one or two adults and no children depending on whether one or both parents are present in the eligible unit.

(c) For families in receipt of AFDC-related Medicaid on October 1, 1992, a child born to the AFDC-related Medicaid parent beneficiary on or after August 1, 1993 shall be included in the eligible unit for the provision of AFDC- related Medicaid.

(d) Any child included in AFDC-related Medicaid eligible unit who subsequently becomes a parent-minor and either establishes his or her own separate AFDC-related Medicaid eligible unit or remains in the eligible unit of the parent or caretaker relative shall be entitled to AFDC-related Medicaid.

(e) An individual who incurs a penalty of ineligibility shall not be included in the eligible unit and his or her needs shall not be taken into account in determining the family's need for AFDC-related Medicaid. (See N.J.A.C. 10:69-3.14 regarding income of a noneligible parent.)

(f) The term child in AFDC-related Medicaid shall be understood to refer to one or more eligible children residing in the home of the applicant parent(s).

1. The relationship of the child(ren) to the parent or parent-person applying for AFDC-C or the child(ren) to the natural or adoptive parents applying for AFDC -F or -N shall be established by use of documentary or nondocumentary sources of evidence. Some examples of these types of evidence are given in N.J.A.C. 10:69-3.3(b)2.

(g) Potential eligibility for other programs is as follows:

1. The CBOSS shall explore potential eligibility for AFDC-C or -F before determining eligibility for AFDC-N.

2. When applicant family members, including a disabled or blind child, appear to be eligible for other programs (for example, Supplemental Security Income), the advantages and disadvantages of each program shall be explained to the applicant. He or she shall have the right to decide under which program(s) he or she wishes to apply. In the event an applicant parent(s) is found to be eligible for another program of AFDC-related Medicaid coverage, such parent(s) may nevertheless apply for AFDC-C,-F or -N as appropriate, for the eligible child(ren) only.

10:69-3.8 Applicant and eligible unit AFDC-C,-F and-N

(a) The term applicant in AFDC-C refers to the parent(s) or parent-person(s) who makes an affirmative decision to apply for Medicaid or, when the applicant is incapacitated or alleged incompetent, someone acting responsibly for him or her (see N.J.A.C. 10:69-2.4(b)1) in order to maintain and provide for one or more dependent children of eligible age who are in his or her care or custody. It may also include the stepparent, at the applicant's option, if the marriage meets the qualifications of N.J.A.C. 10:69-10.33. If the AFDC-C related Medicaid beneficiary parent marries a non-needy individual on or after October 1, 1992 and the provisions of N.J.A.C. 10:69-10.34 apply, the AFDC-C beneficiary natural or adoptive parent, the stepparent and that stepparent's own natural or adoptive child(ren) as well as the natural or adoptive AFDC-C beneficiary parent shall be excluded from the eligible unit.

1. When the applicant applying for AFDC-C based on continued absence of a natural or adoptive parent is himself or herself a natural or adoptive parent, he or she must apply for himself or herself and children of eligible age, unless such parent is an SSI beneficiary in which case he or she may apply for the eligible children only (see N.J.A.C. 10:69-3.7).

2. When the applicant in AFDC-C is a parent-person, he or she has the option of applying for himself or herself and the eligible children or only for the eligible children in his or her care and custody.

3. In all AFDC-C cases, an application shall be signed by the adult member(s) or parent-minor (see N.J.A.C. 10:69-3.11(a)) of the unit for which AFDC- related Medicaid coverage is requested.

4. When the AFDC-C child(ren) lives with a parent-person(s), the application shall be executed by the parent-person who shall be the designated payee.

i. A pregnant woman under age 21 should be evaluated for eligibility for Medicaid Special under the criteria established in N.J.A.C. 10:69-12.

ii. A pregnant women who does not qualify for Medicaid Special should be evaluated against the eligibility criteria in N.J.A.C. 10:72. If the applicant meets all the eligibility requirements for the New Jersey Care ... Special Medicaid Programs requirements except for income, the application shall be referred to NJ KidCare (see N.J.A.C. 10:79)

for possible eligibility.

iii. Eligibility for AFDC-related Medicaid following the birth of the child is based on the requirements and standard for AFDC-C, -F, or -N, whichever is applicable.

(b) The term applicant in AFDC-F and -N refers to natural or adoptive parents, not incapacitated, both of whom shall be required to execute the formal written application unless one such parent is not available for reasons beyond the family's control. This parent shall be required to sign as promptly as he or she is available for such purpose. (See N.J.A.C. 10:69-2.13 relevant to companion cases.)

(c) To be eligible for AFDC-C, an individual must be either a citizen of the United States or an eligible alien. (See N.J.A.C. 10:69-3.9 for alien status that may qualify an individual for AFDC-related Medicaid.)

1. Income of those ineligible individuals who are parents of otherwise eligible children shall be considered available to the eligible family and shall be calculated in accordance with the stepparent deeming formula at N.J.A.C. 10:69-2.9.

2. Medicaid coverage through AFDC-related Medicaid shall not be granted to an ineligible alien or to aliens admitted as students or visitors. However, United States citizen/eligible alien children of illegal aliens may still be eligible to receive AFDC-C, -F or -N segment-related Medicaid. The situations described in (c)2i through iii below serve as illustrations of how to determine AFDC-C, -F, or -N status for U.S. citizen/eligible alien children of ineligible aliens.

i. In the case of one ineligible alien parent with U.S. citizen/eligible alien children, the children shall be eligible for Medicaid as AFDC-C due to parental deprivation (one parent is absent). The eligible unit shall consist of the U.S. citizen/eligible alien children. There is no Medicaid eligibility for the ineligible alien parent but his or her income shall be counted as available to the eligible unit in accordance with N.J.A.C. 10:69-11.9(d).

ii. If one parent is an eligible alien, or U.S. citizen and qualifies the children for Medicaid as AFDC-F segment, the children and eligible alien/citizen parent shall be eligible for Medicaid under the -F segment. The other parent's income shall be counted as available to the eligible unit in accordance with N.J.A.C. 10:69-11.9(d) but he or she is ineligible for Medicaid.

iii. If one or both parents are not eligible aliens or U.S. citizens and the parents do not meet the criteria to qualify the children for Medicaid under the AFDC-F segment, the children may, if otherwise eligible, qualify for NJ KidCare coverage if they are U.S. citizens/eligible aliens. If both parents are ineligible aliens, the parents' income is counted as available to the eligible unit in accordance with N.J.A.C. 10:69-11.9(d) and the children form an -N segment unit of their own. If one parent is an ineligible alien and the other parent is an eligible alien/U.S. citizen, the children plus the eligible alien/U.S. citizen parent form an AFDC-N segment unit.

10:69-3.9 AFDC-related Medicaid citizenship/eligibility requirements

(a) In order to be eligible for the Medicaid program, an individual must be a citizen of the United States, or an alien lawfully admitted for permanent residence, or an alien approved for temporary residence who can be classified as an eligible alien in accordance with this chapter.

1. The term "citizen of the United States" includes persons born in Puerto Rico, Guam, the Virgin Islands, Swain's Island, American Samoa, and the Northern Mariana Islands.

(b) The following aliens if present in the United States prior to August 22, 1996, and if otherwise meeting the eligibility criteria, are entitled to full Medicaid benefits:

1. An alien lawfully admitted for permanent residence;
2. A refugee admitted pursuant to section 207 of the Immigration and Nationality Act;
3. An asylee admitted pursuant to section 208 of the Immigration and Nationality Act;
4. An alien whose deportation has been withheld pursuant to section 243(h) of the Immigration and Nationality Act;
5. An alien who has been granted parole for at least one year by the Immigration and Naturalization Service pursuant to section 212(d)(5) of the Immigration and Nationality Act;
6. An alien who has been granted conditional entry pursuant to section 203(a)(7) of the Immigration law in effect prior to April 1, 1980;
7. An alien who is granted status as a Cuban or Haitian entrant as defined by section 501(e) of the Refugee Education Assistance Act of 1980;
8. An American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act apply;
9. A member of an Indian tribe as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act;
10. An alien who is admitted to the United States as an Amerasian immigrant pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act of 1988;
11. An alien who is honorably discharged or who is on active duty in the United States Armed Forces and his or her spouse and the unmarried dependent children of the alien or spouse; and
12. Certain legal aliens who are victims of domestic violence and when there is a substantial connection between the battery or cruelty suffered by an alien and his or her need for Medicaid benefits, subject to certain conditions described below:

i. The alien has been battered or subjected to extreme cruelty in the United States by a spouse or a parent;

ii. The alien has been battered or subjected to extreme cruelty in the United States by a member of the spouse's or parent's family residing in the same household of the alien and the spouse or parent acquiesced to such battery or cruelty;

iii. The alien's child has been battered or subjected to extreme cruelty in the United

States by the spouse or the parent of the alien (without the active participation of the alien in the battery or cruelty); or

iv. The alien's child has been battered or subjected to extreme cruelty in the United States by a member of the spouse's or parent's family residing in the same household as the alien and the spouse or parent acquiesced to and the alien did not actively take part in such battery or cruelty.

v. In addition to the conditions described in (b)12i through iv above, if the individual responsible for the battery or cruelty continues to reside in the same household as the individual who was subjected to such battery or cruelty, then the alien shall be ineligible for full Medicaid benefits.

vi. The county board of social services shall apply the definitions "battery" and "extreme cruelty" and the standards for determining whether a substantial connection exists between the battery or cruelty and the need for Medicaid as issued by the Attorney General of the United States under his or her sole and unreviewable discretion.

(c) The following aliens entering the United States on or after August 22, 1996, and if otherwise meeting the eligibility criteria, are entitled to Medicaid benefits:

1. An alien lawfully admitted for permanent residence but only after having been present in the United States for five years;

2. A refugee admitted pursuant to section 207 of the Immigration and Nationality Act;

3. An asylee admitted pursuant to section 208 of the Immigration and Nationality Act;

4. An alien whose deportation has been withheld pursuant to section 243(h) of the Immigration and Nationality Act;

5. An alien who has been granted parole for at least one year by the Immigration and Naturalization Service pursuant to section 212(d)(5) of the Immigration and Nationality Act but only after the alien has been present in the United States for five years;

6. An alien who has been granted conditional entry pursuant to section 203(a)(7) of the Immigration law in effect prior to April 1, 1980, but only after the alien has been present in the United States for five years;

7. An alien who is granted status as a Cuban or Haitian entrant pursuant to section 501(e) of the Refugee Education Assistance Act of 1980;

8. An American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act apply;

9. A member of an Indian tribe as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act;

10. An alien who is admitted to the United States as an Amerasian immigrant pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act of 1988;

11. An alien who is honorably discharged or who is on active duty with the United States Armed Forces and his or her spouse and the unmarried dependent children of the alien or spouse; and

12. Certain aliens who are victims of domestic violence as specified in (b)12 above,

but only after the alien has been present in the United States for five years.

(d) Any alien who is not an eligible alien as specified in (c) and (d) above, is ineligible for Medicaid benefits. Any such alien is, if a resident of New Jersey and if he or she meets all other Medicaid eligibility requirements, entitled to Medicaid coverage for the treatment of an emergency medical condition only.

1. An emergency medical condition is one of sudden onset that manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

i. Placing the patient's health in serious jeopardy;

ii. Serious impairment to bodily functions; or

iii. Serious dysfunction of any bodily organ or part.

2. An emergency medical condition includes all labor and delivery for a pregnant woman. It does not include routine prenatal or post-partum care.

3. Services related to an organ transplant procedure are not covered under services available for treatment of an emergency medical condition.

(e) Persons claiming to be citizens and eligible aliens shall provide the county board of social services with documentation of citizenship or alien status.

(f) As a condition of eligibility, all applicants for AFDC-related Medicaid (except for those applying solely for services related to the treatment of an emergency medical condition) shall sign a declaration under penalty of perjury that they are a citizen of the United States or an alien in a satisfactory immigration status. In the case of a child or incompetent applicant, another individual on the applicant's behalf shall complete the same written declaration under penalty of perjury. When the applicant or other person for whom the application is being made is an alien, the applicant's alien status shall be verified through evidence provided by the applicant with the United States Immigration and Naturalization Service. (Refer to N.J.A.C. 10:69-2 for alien verification procedures through the Systemic Alien Verification for Entitlements (SAVE) program.)

1. The following are acceptable documentation of United States citizenship:

i. A birth certificate;

ii. A religious record of birth recorded in the United States or its territories within three months of birth. The document must show either the date of birth or the individual's age at the time the record was created;

iii. A United States passport (not including limited passports which are issued for periods of less than five years);

iv. Report of Birth Abroad of a Citizen of the U.S. (Form FS-240);

v. U.S. Citizen I.D. Card (INS Form-197, Naturalization Certificate (INS Form N-550 or N-570);

vi. Certificate of Citizenship (INS Form N-560 or N-561);

vii. Northern Mariana Identification Card (issued by the INS to a collectively

naturalized citizen of the United States who was born in the United States before November 3, 1986);

viii. American Indian Card with a classification code "KIC" (issued by the INS to identify U.S. citizen members of the Texas Band of Kickapoos); or

ix. A contemporaneous hospital record of birth in one of the 50 states, the District of Columbia, Puerto Rico (on or after January 13, 1941), Guam (on or after April 10, 1899), the U.S. Virgin Islands (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands (unless the person was born to foreign diplomats residing in any of these jurisdictions).

2. The following sets forth acceptable documentation for eligible aliens:

i. If an applicant presents an expired INS document or is unable to present any document demonstrating his or her Immigration status, the county board of social services shall refer the applicant to the local INS district office to obtain evidence of status. If, however, the applicant provides an alien registration number, but no documentation, the county board of social services shall file INS Form G-845 along with the alien registration number with the local INS district office to verify status;

ii. Lawful Permanent Resident--INS Form I-551, or for recent arrivals, a temporary I-551 stamp in a foreign passport or on Form I-94;

iii. Refugee--INS Form I-94 annotated with stamp showing entry as refugee under section 207 of the Immigration and Nationalization Act and date entry into the United States; INS Form I-688B annotated "274a. 12(a)(3)," I-766 annotated "A3," or I-571. Refugees usually adjust to Lawful Permanent Resident status after 12 months in the United States, but for purposes of determining Medicaid eligibility they are considered refugees. Refugees whose status has been adjusted will have INS Form I-551 annotated "RE-6," "RE-7," "RE-8" or "RE-9";

iv. Asylees--INS From I-94 annotated with a stamp showing grant of asylum under section 208 of the Immigration and Nationality Act, a grant letter from the Asylum Office of the Immigration and Naturalization Service, Forms-688B annotated "274a. 12(a)(5)" or I-766 annotated "A5";

v. Deportation Withheld--Order of an Immigration Judge showing deportation withheld under section 243(h) of the Immigration and Nationality Act and the date of the grant, or INS Form I-688B annotated "274a. 12(a)(10)" or I-766 annotated "A10";

vi. Parole for at Least a Year--INS Form I-94 annotated with stamp showing grant of parole under section 212(d)(5) of the Immigration and Nationality Act and a date showing granting of parole for at least a year;

vii. Conditional Entry under Law in Effect before April 1, 1980--INS Form I-94 with stamp showing admission under section 203(a)(7) of the Immigration and Nationality Act, refugee-conditional entry, or INS Forms I-688B annotated "274a. 12(a)(3)" or I-766 annotated "A3";

viii. Cuban Haitian Entrant--INS Form I-94 stamped "Cuban/Haitian Entrant under section 212(d)(5) of the INA";

ix. An American Indian born in Canada--INS Form I-551 with code S13 or an

unexpired temporary I-551 stamps (with code S13) in a Canadian passport or on Form I-94;

x. A member of certain Federally recognized Indian tribes--a membership card or other tribal document showing membership in tribe is acceptable documentation; or

xi. Amerasian Immigration--INS Form I-551 with the code AM1, AM2, or AM3 or passport stamped with an unexpired temporary I-551 showing a code AN6, AM7 or AM8;

3. For aliens subject to the five-year waiting period before eligibility for Medicaid can be established, the date of entry into the United States shall be determined as follows:

i. On INS Form I-94, the date of admission should be found on the refugee stamp. If missing, the county board of social services should contact the INS local district office by filing Form G-845, attaching a copy of the document.

ii. If the alien presents INS Form I-688B (Employment Authorization Document), I-766, or I-571 (Refugee Travel Document), the county board of social services shall ask the alien to present Form I-94. If that form is not available, the county board of social services shall contact the INS via the submission of Form G-845, attaching a copy of the documentation presented.

iii. If the alien presents a grant letter or court order, the date of entry shall be derived from the date of the letter or court order. If missing, the county board of social services shall contact the INS by submitting a Form G- 845, attaching a copy of the document presented.

4. For aliens who present themselves as on active duty or honorably discharged from the United States Armed Forces, the following serve as documentation:

i. For discharge status, an original, or notarized copy, of the veteran's discharge papers issued by the branch of service in which the applicant was a member.

ii. For active duty military status, an original, or notarized copy, of the applicant's current orders showing the individual is on full-time duty with the U.S. Army, Navy, Air Force, Marine Corps, or Coast Guard (full time National Guard duty does not qualify), or a military identification card (DD Form 2 (active)).

(f) A self-declaration under penalty of perjury may be accepted pending receipt of acceptable documentation.

1. A statement of citizenship/eligible alien status and signature attesting to citizenship/eligible alien status shall be provided before benefits can be issued to that individual. An adult eligible family member or applicant for the family in the absence of an adult family member shall sign for members under 18 years of age.

2. If a signature is not provided for all eligible family members by the end of the 30-day processing standard, then only those individuals for whom there is a signature shall be eligible for benefits provided they meet all other eligibility requirements.

3. The needs of ineligible members shall not be considered when determining eligibility and benefits for the remaining family members.

10:69-3.10 Parent in AFDC-C, -F and -N related Medicaid segments

(a) In AFDC-C, the term "parent" shall refer to the natural and/or adoptive parent(s) or parent-person(s).

1. By law, in AFDC-C certain relatives shall be recognized as taking the place of a parent. The term "parent-person" is used to designate one or more such relatives who include those of half-blood, those persons of preceding generations denoted by prefixes "grand" and "great," brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew or niece. Such relative must be one with whom the dependent child is living, in a place of residence in New Jersey maintained by one or more such relatives as his or her or their own home.

i. A home is the family setting maintained or in process of being established as evidenced by assumption and continuation of responsibility for day to day care of the child by the relative with whom the child is living. A home exists so long as the relative exercises responsibility for the care and control of the child, even though either child or the relative is temporarily absent from the customary family setting.

ii. AFDC-related Medicaid eligibility cards can be issued on behalf of child(ren) to persons authorized to act for specified relatives in emergency situations that deprive the child of the care of the relative through whom he or she has been receiving care, for a temporary period necessary to make and carry out plans for the child's continuing care and support.

2. Under New Jersey law, relatives of persons who adopt children become legally related to such adopted children to the same extent that they are related to natural children of the adopting parent.

3. Spouses of any persons named in the groups in (a)1 and 2 above may be considered "parent-persons" even though death or divorce has terminated the marriage.

(b) In AFDC-F, the term "parent" refers to the natural or adoptive parents who have at least one eligible child residing with them who is under age 18 or under age 19 and a full-time student in a secondary school or in the equivalent level of vocational or technical training and is reasonably expected to complete the program before reaching age 19.

(c) In AFDC-N, the term "parent" is used to refer to two adults of the opposite sex who have at least one eligible child residing with them who is under age 18 or under age 19 and a full-time student in a secondary school, or in the equivalent level of vocational or technical training, and is reasonably expected to complete the program before reaching age 19. This child must be the natural child of both parents or the natural child of one and adopted by the other or a child adopted by both.

10:69-3.11 Parent-minor in AFDC-related Medicaid

(a) When a parent-minor(s) and the parent-minor's child is residing with his or her

natural or adoptive parent(s), income deeming rules apply to determining the eligibility of the parent-minor (see N.J.A.C. 10:69-3.14).

(b) When a parent-minor(s) and the parent-minor's child reside with an adult relative other than their natural/adoptive parent(s), or as a separate household, the parent-minor's natural or adoptive parents shall be evaluated as legally responsible relatives in accordance with the provisions of N.J.A.C. 10:69-3.10.

(c) When a parent-minor and his or her child(ren) are living in the home of the parent-minor's natural or adoptive parents, or relatives who qualify as parent-persons(s) of the parent-minor, and such parent(s) or parent-persons are themselves eligible for AFDC-related assistance, the eligible family shall consist of the parent-minor, the parent-minor's child, the parent-minor's parent(s) and the parent-minor's brothers and sisters.

10:69-3.12 Circumstances requiring special handling

(a) Circumstances requiring special handling which are not conditions of eligibility include the mental competency of applicant. Any person who applies for assistance shall be presumed to be mentally competent unless there is professional diagnostic evidence to the contrary, or unless there is question regarding competency because of certain observable behavior or reactions.

(b) Criteria for alleged incompetence of an applicant include:

1. Inability or substantial difficulty in giving simple identifying information such as his or her correct name, address, names of members of his or her family, names of persons with whom he or she lives or has frequent association (during the course of the interview references should be made to these previously directed questions and the consistency of the response noted); inability to report in a general way factual information about his or her economic status, his or her education, his or her employment history (if any), and his or her medical history; and
2. Insistence on relating irrelevant information in a way that appears genuinely unbalanced.

(c) If, after considering the client's response according to the criteria in (b) above, the CBOSS has reasonable doubt of his or her mental competency (alleged incompetence), the eligibility worker shall accept an application from him or her and immediately refer the care to the social service unit to locate a protective payee.

(d) If any of the following conditions appear to exist in the relationship between parent and child, the case shall immediately be referred to the social service unit which shall contact the Division of Youth and Family Services (DYFS) for appropriate action. The CBOSS shall provide DYFS with pertinent information as appropriate and shall cooperate in planning and implementing action in the best interest of the child. (See

also N.J.A.C. 10:69-7.40(c) 2.)

1. Physical or sexual abuse or cruel treatment;
2. Exploitation by prostitution or overwork, having the child beg or involving the child in illegal activities; or
3. Neglect as shown by apparent malnutrition or lack of supervision necessary for the health and safety of the child.

(e) The conditions in (d) above shall not affect eligibility of the children to receive AFDC-related Medicaid.

(f) In the event of any indication that the death of a child resulted from abuse or neglect, such matter shall be reported immediately to DYFS.

10:69-3.13 Age requirements

(a) To be considered of eligible age, a child in AFDC-related Medicaid must be under age 18, or under age 19 and a full-time student in a secondary school, or in the equivalent level of vocational or technical training and is reasonably expected to complete the program before reaching age 19. Program completion is defined as the day of ceremonial graduation. See N.J.A.C. 10:69-1.3 for definitions regarding school attendance.

1. When any school or course of training involves attendance during an academic year, a child shall be considered eligible during the summer months when he or she has been accepted for admission in the fall. He or she shall be considered eligible during regular vacation periods unless the educational program has been completed or unless there is verification that the child does not attend or is not acceptable to reenter the program.

(b) A child between 18 and 21 years of age residing with an AFDC-related Medicaid beneficiary family who, except for age, would be eligible for inclusion in the grant, may be eligible for Medicaid Special (see N.J.A.C. 10:69-8.22 through 8.25).

(c) In all segments, when the year of birth can be determined but not the month, July 1 shall be designated to be the birth date. When the month can be determined but not the date, the child shall be eligible until the end of that month.

(d) A beneficiary child cannot be included in the AFDC-related Medicaid eligibility unit in the month after the month in which he or she attains the age when he or she is no longer eligible. Furthermore, a child who attains such age on the first day of the month is not considered to be of eligible age during that month. Additionally, the family ceases to be eligible when the youngest child is no longer of eligible age.

(e) The county board of social services shall establish and maintain appropriate

administrative controls in all AFDC-related Medicaid cases, identifying those members of the eligible unit who may be rendered ineligible because of age. Specifically in this regard, agency controls shall provide advance identification of children attaining age 18 and/or 19, as appropriate for possible referral for general assistance. Parents approaching age 65 should be alerted to the Supplemental Security Income Program.

10:69-3.14 Noneligible persons in the household

When a noneligible individual is living in the household of an eligible unit, a monthly amount shall be recognized as the cost standard for that individual's share of household expenses (see N.J.A.C. 10:69-2.3).

10:69-3.15 Deprivation of parental support or care (AFDC-C)

(a) The statutory definition of "dependent child" sets forth two eligibility factors: economic "need" and "deprivation of parental support or care." These two factors are not identical, and the law requires that both be demonstrated in each case.

(b) "Need" refers to financial eligibility and is determined in accordance with the provisions contained in this chapter.

(c) "Deprivation" is the result of death, physical or mental incapacity, or continued absence from the home of a natural or adoptive parent.

1. A child may be found to be deprived of parental support or care by reason of the documented death of either or both natural or adoptive parent(s).
2. A child may be found to be deprived of parental support or care by reason of the physical or mental incapacity of either or both natural or adoptive parent(s) whether such parent is in the home or is receiving treatment away from home.

(d) The determination of incapacity for persons other than those delineated in N.J.A.C. 10:69-2.7 is made by the Disability Review Section, Division of Medical Assistance and Health Services, on the basis of medical evidence provided by the eligibility worker. This is done in the following way:

1. Forms DRS-1 (or DRS-1A) and DRS-2 must be completed and forwarded with all pertinent medical and hospital records to the Disability Review Section, Division of Medical Assistance and Health Services. This should be done as quickly as possible and shall be completed within 30 days.

i. Give Form DRS-1 or DRS-1A to applicant to be filled in by his or her physician and returned to the welfare agency. If applicant prefers, the eligibility worker shall send the form with signed release to the doctor. The client should be warned that many physicians might not be as prompt in returning this form by mail as when filling it in the client's presence. When the form is returned, it shall be reviewed for completeness, including the physician's signature.

ii. Complete Form DRS-2 (Medical Social Information Report). This requires full and

careful discussion with applicant of the relevant information and possibly a home visit.

(e) The existence of a physical or mental defect, illness, or impairment must be substantiated by current medical information (pertinent within the past three months):

1. This requires evidence of a defect, illness or impairment that is described by an examining physician in such a manner that another physician would reasonably accept the concept that incapacity exists without examining the client.

2. The unsupported opinion of the examining physician that an incapacity exists may, in itself, be accepted. However, material presented under the heading of Social Evaluation and Plan on Form DRS-2 or in other portions of the case record should also be evaluated in demonstrating that incapacity exists.

3. A specific diagnosis is not required.

4. Reports from attending physicians, recognized specialists, hospital or clinic reports or abstracts, photo copies of hospital discharge diagnoses or summaries, objective physical findings, diagnostic studies, and so forth, are all acceptable as supporting material.

(f) The following concern a parent incapacitated by mental defect, illness or impairment:

1. A medical determination that a parent requires institutional care by reason of a diagnosis of mental incapacity does not affect the eligibility of the family. However, the extent of the "incapacity" and its relationship to the ability of the parent to provide "support or care" shall be determined.

2. It is not necessary for purposes of eligibility of the spouse and child to establish whether the incapacitated parent is competent to manage his or her own affairs since the spouse can be payee for the Medicaid card. It is probable that in an instance where the mental condition is of such degree as to raise these questions, the parent should apply for disability assistance under the SSI program.

3. Where the report of the examining physician, institutional or clinic records are available, and appear to provide current data adequate to a determination that "incapacity" exists, these shall be accepted. Whenever, in the judgment of the Disability Review Section, special psychiatric, neurological or psychological examination of testing is necessary or advisable, special consultants or facilities may be used.

(g) The following concern "incapacity" and its relation to employment:

1. When incapacity of a parent persists by reason of a permanent defect, illness or impairment but cannot be considered totally disabling because he or she can do some work, he or she may be considered "incapacitated" when there is evidence to demonstrate that his or her earning ability is limited by reason of the incapacity.

2. Thus, if because of his or her defect, illness or impairment, he or she can engage only in part-time employment (that is, less than 30 hours per week), or his or her wages (or rate of pay) are less than those of other workers in the same type of work, his or her

earnings may be supplemented by an AFDC-C grant to provide adequate support for his or her otherwise eligible dependents and himself or herself. However, a parent who is found able to engage in full time employment at normal rate of pay, but whose earnings are insufficient to adequately support his or her dependents, cannot be considered "incapacitated." In this situation, the CBOSS shall explore eligibility for AFDC-F or -N.

3. When a parent has been determined "incapacitated" by reason of a temporary defect, illness, or impairment and no residual effects are anticipated upon recovery, such a parent shall be considered no longer "incapacitated" upon statement by the treating physician that he or she is able to resume full time gainful employment in his or her previous or a similar occupation.

(h) The following concern refusal to undergo diagnostic evaluation, treatment or related services:

1. In situations where a parent applicant claims to be "incapacitated" but refuses to undergo diagnostic evaluations considered by the Disability Review Section as essential to a determination of his or her "incapacity," the entire family is ineligible for the AFDC-C segment. However, refusal shall not affect the eligibility of his or her spouse and child for AFDC-F or -N.

2. The CBOSS shall make every effort to establish the facts of eligibility on the basis of available evidence in spite of the refusal to undergo diagnostic evaluation.

3. If the family is eligible for Medicaid, the parent claiming incapacity shall be included if the incapacity can be established and the agency determines that the refusal is reasonable based on any of the following criteria:

i. The client is fearful of undergoing treatment, although such fear may appear to be unrealistic or emotional in origin or even irrational, if it is intense enough to adversely affect the result of treatment and a physician recommends against it;

ii. The client might suffer loss of a faculty, or the residual use of a remaining faculty, and he or she is unwilling to take the risk;

iii. The client has religious convictions that do not, in his or her judgment, permit him or her to undergo the recommended treatment; or

iv. The resistance to treatment is an element of the defect, illness or impairment itself.

4. An individual cannot be required to undergo treatment as a condition of eligibility.

(i) An incapacitated parent should be advised of services available through the social service unit and in the community.

(j) Payment for medical expenses incurred on behalf of an AFDC-C-related Medicaid (incapacitated) applicant in the determination of initial eligibility shall be the responsibility of the CBOSS and made from the administration account. The CBOSS shall advise the physician that payment of the fee will be at the applicable rate contained in the schedule of fees for professional and diagnostic services set forth at

N.J.A.C. 10:71-3.13(l). Transportation for diagnostic evaluations shall be made available.

10:69-3.16 Continued absence of parent from the home

(a) The county board of social services shall make every reasonable effort to locate an absent parent in order to obtain support payments. An absent parent shall be given the opportunity to voluntarily support his or her child, but it shall be explained to both parents that the extent of support shall be established by the court.

(b) Each applicant and beneficiary is required to cooperate in obtaining support and establishing paternity whenever necessary as a condition of eligibility for AFDC-related Medicaid in accordance with the procedures set forth in N.J.A.C. 10:69-11.

(c) "Continued absence from the home" (see N.J.A.C. 10:69-2.8(d)) may be for any reason. The following are some of the ways to establish absence:

1. Documentary proof of divorce, pending divorce, or separation agreement (that is, official legal documents, court or attorney records or newspaper accounts) may be indicative of "continued absence from the home" but shall be verified and documented in the case file.

2. A parent shall be considered absent from the home during a period of incarceration. There is a possible situation that a parent whose imprisonment is expected to be of short duration may also be "incapacitated." Where this appears to be so, consideration shall be given to possible eligibility under the "incapacity" factor rather than the "absence" factor.

i. Evidence to substantiate "absence" when a parent is incarcerated in the State penal or correctional institution shall be secured by use of Forms PA- 17B and PA-17C. When the "tear sheet" has been returned and the date of release determined, the CBOSS shall immediately redetermine the basis of continued eligibility and note it in file.

ii. With regard to the absent parent's incarceration in a county or municipal jail, the CBOSS shall need to develop a procedure in cooperation with each jail within its jurisdiction regarding exchange of information both at time of initial AFDC-C application and at time of release of incarcerated parents. PA-17B and PA-17C are not appropriate and shall not be used for local jails. Procedures established by the CBOSS with regard to county and municipal jails may vary from a formal procedure to personal telephone contacts or visits, provided the information required is obtained and acceptable to the CBOSS. In situations where the absent parent is incarcerated in another county, it is recommended that the CBOSS of such county be consulted regarding its method for contacting county and municipal jails and a mutually agreeable decision made as to which county will contact the jail.

3. A parent who is a convicted offender but is permitted to live at home while serving a court-imposed sentence by performing unpaid public work or unpaid community service during the workday is considered absent from the home. The CBOSS shall verify such

court-imposed sentence and document its findings in the case record prior to case validation.

i. Such parent shall not be eligible for AFDC-related Medicaid benefits.

ii. Income, if any, of such a parent shall be treated in accordance with N.J.A.C. 10:69-11.3(b).

iii. For child support and paternity purposes, the family is considered to be intact and is not subject to the CSP process.

4. A parent who has been deported from the United States shall be considered "continuously absent from the home." There must be proof of the deportation by inspection of an official notice or statement in possession of the applicant, or by obtaining written confirmation from the Immigration authorities. The information should include the date and conditions of deportation. The current address of the deported parent and his or her circumstances should also be obtained from the applicant parent, if known, and noted in the eligibility file.

5. A parent who is separated from his or her family because of uniformed service shall not be considered "continuously absent from the home" if such absence is occasioned solely by reason of active uniformed service. If, however, continued absence would exist irrespective of performance of uniformed service (for example, desertion of the family before or after entry into uniformed service or divorce), eligibility for AFDC-C may be established. Such findings shall be noted in the eligibility file.

i. When a parent serving in the uniformed services is not continuously absent from the home, the family may be eligible under the AFDC-F or-segment.

ii. "Uniformed service" is defined to mean the Army, Navy, Air Force, Marine Corps, Coast Guard, Environmental Sciences Services Administration, Public Health Service of the United States, and the National Guard.

6. When a parent is temporarily absent in order to receive treatment for a mental or physical illness, defect or impairment, the family should be considered under the incapacity factor.

7. When the natural parents of a child are not married to each other and one lives apart from the children, a continuing relationship between the parents is not of itself evidence of a continuing relationship with the children. When there is no evidence of a continuing relationship between the absent parent and child(ren), "continuous absence" applies.

(d) The following concern the eligibility of a child born of unmarried parents:

1. The eligibility of a child is not affected by the fact that he or she was born of unmarried parents. The initiation of proceedings to determine paternity and to establish financial responsibility of reputed father shall not be a condition of eligibility.

2. Parents of a child born of unmarried parents are equally responsible for his or her support.

i. A father may voluntarily establish the fact of his paternity and establish with the CBOSS the extent of his ability to support his child. Voluntary support payments do not

legally establish paternity and cannot be enforced in the absence of legally established paternity. A mother may initiate proceedings to establish paternity and/or gain support from the reputed father. She shall be informed of the advantages to the child of having paternity established legally such as certain inheritance rights and social security benefits. (See N.J.A.C. 10:69-8.5(c).)

3. Court action may be necessary to establish paternity or to obtain support; in the absence of the mother's willingness to initiate such proceedings, the county board of social services cannot refuse to establish Medicaid eligibility but may initiate proceedings (see N.J.A.C. 10:69- 11.9(d)). This provision shall be fully explained to each applicant mother of a child born of unmarried parents.

4. By law, the CBOSS are authorized to initiate proceedings to establish paternity and responsibility for support of a child born of unmarried parents who is a beneficiary of AFDC-related Medicaid (see N.J.A.C. 10:69-11.9). This authority should be used only when neither parent is willing to initiate proceedings. Filiation proceedings should be initiated in the Family Division of Superior Court.

(e) A parent may be considered continuously absent from the home when a condition of desertion is established. A desertion may already be a matter of public record, or may be alleged or presumed.

1. Desertion may be established by verifying that a parent has been convicted of desertion, charged with desertion by indictment or by filing of a complaint with the court or named as defendant in an action for divorce on grounds of desertion. Methods of verification would include records of the county prosecutor's office, juvenile and domestic relations court, municipal court where the complaint was filed, or, in the case of a divorce action documents or records in the possession of the applicant, appropriate court or attorneys.

2. Where desertion has not been established but the applicant alleges that the child for whom he or she is applying has been deserted, the factor of continuing absence by reason of "desertion" shall be considered. The CBOSS shall request of the applicant/beneficiary, during the completion of the application (Form PA-1J), information relating to the deserting parent's whereabouts and ask applicant/beneficiary to acknowledge such desertion. By signing the application, the client attests to the accuracy and verity of his or her statements.

i. The continuing effort to locate absent parents is a responsibility of the CBOSS. Since the law permits use of Social Security numbers to aid in location of deserting parents, the CBOSS shall make every effort to obtain such information.

(f) A parent shall be considered "continuously absent from the home" when by mutual agreement, not legal action, the parents have informally separated, for example, one parent is out of the home and such absent parent is not exercising responsibility as a member of the household consistent with the definition of "continued absence" although he or she may be making or demonstrating to the CBOSS his or her "intent" to make

some financial contribution to the family.

(g) The CBOSS is charged with the general responsibility of reducing the extent of the beneficiary family's reliance on AFDC-related Medicaid. In striving for this objective, the CBOSS shall attempt to effect a resumption of medical support provided to the AFDC-related Medicaid family by the absent parent within the ability of such parent. In cases of absent parent(s) whose whereabouts are unknown, the CBOSS will forward Form PA-450 to the State Parent Locator Service (see N.J.A.C. 10:69-11.9).

1. This is a service to aid and supplement local efforts; the basic obligation for locating parents rests with the county's parent locator service.

10:69-3.17 Work criteria; determination of principal earner

(a) In order to determine qualification for AFDC-F and -N eligibility, a determination shall first be made as to which parent is the principal earner in that family.

1. The "principal earner" or primary wage earner is whichever parent earned the greater amount of income in the 24-month period immediately preceding the month of application for AFDC-F or -N. This designation thereafter shall apply for each consecutive month for which the family receives AFDC-F or -N.

2. When either parent can qualify as the principal earner because both parents earned an identical amount of income in such 24-month period, the principal earner shall be whichever parent earned the greater amount of income in the most recent consecutive six-month period of such 24-month period.

3. If both parents earned an identical amount of income in such six-month period, the CBOSS shall designate which parent shall be the principal earner.

(b) AFDC-F segment eligibility for families with either natural or adoptive parents in the home is based on deprivation of parental support to the children in that family due to unemployment of the parent who is designated the principal earner. Form PA-22, Employment Criteria for AFDC-F families, is to be used by the CBOSS in determining eligibility for AFDC-F. Form PA-22 may be reproduced by each CBOSS. After the initial application, the CBOSS shall reexamine Form PA-22 whenever the circumstances surrounding employment in a two-parent household change. To qualify for AFDC-F, the following criteria shall be met.

1. The principal earner has been unemployed or underemployed for at least 30 days prior to the receipt of AFDC-related Medicaid;

i. Unemployed or underemployed is defined as:

(1) Not working at all;

(2) Working less than 100 hours a month; or

(3) Participating in work which exceeds the 100 hour per month standard but is intermittent and the excess hours are of a temporary nature, as evidenced by the fact that the principal earner was under the 100 hours standard for the two prior months and is expected to be under the standard during the next month;

2. The principal earner has not, without good cause, within such 30-day period prior to the receipt of AFDC-related Medicaid, refused a bona fide offer of employment or training for employment;

3. The principal earner has not refused to apply for or accept unemployment compensation for which he or she qualifies;

i. An individual shall be deemed "qualified" for unemployment compensation under the State's unemployment compensation law if he or she would have been eligible to receive such benefits upon filing application, or he or she performed work not covered by such law which, if it had been covered, would (together with any covered work he or she performed) have made him or her eligible to receive such benefits upon filing application;

ii. The applicant shall also be informed that refusal to apply for or accept unemployment compensation for which he or she qualifies will render the principal earner and the second ineligible for Medicaid; and

4. The principal earner has six or more quarters of work (as described in (b)4i below), no more than four of which may be quarters of work over his or her lifetime as defined in (b)4i(2) below, within any 13 calendar-quarter period ending within one year prior to the application for such aid; or, within such one-year period, received unemployment compensation under an unemployment compensation law of a State or of the United States; or was qualified (see (b)3i above) for such compensation under the State's unemployment compensation law.

i. A "quarter of work" with respect to any individual means a period (of three consecutive calendar months ending on March 31, June 30, September 30, or December 31) in which:

(1) The individual received earned income of not less than $50.00;

(2) The individual attended full-time, an elementary school, a secondary school, or a vocational or technical training course that is designed to prepare the individual for gainful employment, or in which such individual participated in an education or training program established under the Job Training Partnership Act, Public Law 97-300; or

(3) The individual participated in the Community Work Experience Program or WIN (Work Incentive Program) prior to October, 1990, or the Job Opportunities and Basic Skills Training Program (JOBS/REACH or FDP in New Jersey).

(c) AFDC-N segment eligibility for families with both natural or adoptive parents in the home when the principal earner does not satisfy the Federal work criteria delineated in

(b) above is based on the deprivation of parental support to the children in that family due to underemployment of the primary wage earner (principal earner). The following additional sanctions shall apply in AFDC-N segment cases if financial eligibility is the result of voluntary cessation of employment without good cause.

1. If AFDC-N segment financial eligibility is the result of voluntary cessation of employment without good cause as set forth at N.J.A.C. 10:86, including cessation of

employment due to inappropriate work habits by either of the applicant parents, regardless of reason, within 90 days prior to the date of application for AFDC-related Medicaid, neither of the parents shall be included in the eligible family. This penalty shall extend for a period of 90 days beginning with the date of the termination of employment. Eligibility shall be considered only for the children in such instances.

i. At the end of the 90-day penalty period, the parents may be granted assistance under AFDC-N so long as other non-financial eligibility requirements are satisfied and financial need exists.

2. If an employed primary wage earner (principal wage earner) voluntarily ceases employment for whatever reason without good cause (see N.J.A.C. 10:86), both parents' needs shall be deleted from the eligible family under AFDC-N.

10:69-3.18 Residence requirements

The law requires that an applicant for or beneficiary of assistance shall reside in New Jersey. Any person who responds affirmatively to the question on the application "Do you plan to continue living in New Jersey?" fulfills this requirement. The requirement is also satisfied when the person resides in the State having entered with a job commitment or is seeking employment even if he or she is currently unemployed.

10:69-3.19 Temporary absence from State

(a) A beneficiary family may leave the State for up to a one-month period with no resultant effect upon Medicaid eligibility. If absence from the State shall exceed or is anticipated to exceed the one month period, the family shall immediately notify the county board of social services in order to request continuation of Medicaid for a three-month period following the month of departure, or any portion thereof. Such notice of intent to temporarily leave the State and request to continue Medicaid should be given to the CBOSS as far in advance of a planned absence as possible. Approval of such Medicaid continuation may be granted by the CBOSS quarterly for a period not to exceed one year. Authorization for extension of assistance beyond one year requires approval of the Division of Medical Assistance and Health Services.

(b) Upon establishment of the fact that the beneficiary family still considers its permanent residence to be New Jersey and that it plans to return thereto, continuation of Medicaid may be granted for the following reason(s):

1. Ill health;
2. Inability to travel of one or more members;
3. Mental or physical welfare; or
4. Family responsibility (for example, settling affairs of deceased).

(c) Medicaid coverage shall not be automatically continued without inquiry with respect to a beneficiary family that leaves New Jersey when there has been no information provided to the agency establishing that the absence is purely temporary. All

beneficiary families shall be advised that it is their responsibility to notify the CBOSS personally or in writing and arrange in advance, so far as possible, for any plan to leave New Jersey for any period in excess of one month if they wish Medicaid coverage to be continued during absence from the State. The decision whether or not to leave New Jersey, whether it is for permanent removal or temporary absence, shall rest with the beneficiary family and does not require official approval or disapproval by the agency.

(d) Whenever a beneficiary family wishes to leave New Jersey either to establish a permanent place of abode or for a temporary visit, they shall be advised of the effects of this plan on their eligibility for continued Medicaid during the temporary absence.

(e) If a beneficiary family has left the State without notifying the agency of the nature, purpose and expected duration of such absence, the CBOSS will make every effort to inform the family in writing of the information required to termination of their Medicaid coverage. This notice shall include a sentence in Spanish cautioning the client that inaction may jeopardize continued AFDC-related Medicaid and that if they do not understand it they should get help. Upon receipt of such information from the beneficiary family or a collateral source, Medicaid may be continued if deemed necessary by the CBOSS. Medicaid eligibility shall continue issued until the CBOSS has determined whether the beneficiary has or has not abandoned State residency, in accordance with N.J.A.C. 10:69-3.23.

10:69-3.20 Management of out-of-State case records

(a) The CBOSS shall maintain an up-to-date record of all cases of beneficiaries approved to receive Medicaid while out of the State.

(b) There shall be monthly supervisory review of the status of these cases to assure that no Medicaid card is issued beyond the period for which approval has been given, unless and until extension of continued Medicaid coverage is approved, and that no Medicaid card is issued when and if eligibility ceases.

10:69-3.21 Abandonment of State residence

Medicaid coverage shall not be provided to beneficiaries who abandon State residence by both terminating any actual place of abode in New Jersey and establishing an actual place of abode in another state with apparent intent to remain permanently absent from New Jersey. Abandonment shall also encompass situations of prolonged absence from New Jersey for an indefinite period for purpose other than temporary visit, and shall be reason for termination of eligibility. Under circumstances delineated above, timely notice need not be provided to the beneficiary, in accordance with N.J.A.C. 10:69-6.12(a).

10:69-3.22 Notice of termination

Beneficiaries who are receiving AFDC-related Medicaid coverage out-of-State shall be afforded the same full advance notice including information about their right to a fair hearing in accordance with N.J.A.C. 10:69-6. A copy of any such notice shall be sent to any out-of-State agency with which there has been communication regarding the case.

10:69-3.23 County residence for identification

(a) Residence in a county is not an eligibility requirement. A county of residence is necessary to identify which CBOSS is legally responsible for receipt, registration and processing an application and for issuance of a Medicaid card, but shall not preclude or limit the opportunity for any person residing in New Jersey to apply for and receive Medicaid coverage without delay.

(b) Wherever a family is living shall be considered that family's county residence. When a beneficiary family, or any member thereof, goes to another county or state for the purpose of a temporary visit, that county or state shall not become their residence unless N.J.A.C. 10:69-3.26 applies.

(c) A care facility or a public or private institution of custodial, curative, or penal character shall not be considered an individual's customary residence. Upon leaving such facility, the individual retains the same residence status that he or she had prior to admission. If the family moved during that individual's absence from the home, the county residence shall be that of the family.

10:69-3.24 Change of county residence

(a) Responsibility for AFDC-related Medicaid, and Medicaid extension case management and payment, shall be transferred from one county to the other when a beneficiary family moves to another county.

(b) A temporary visit by either the beneficiary family or any member thereof shall not be considered to be a change of county residence until that visit has continued for more than a three-month period (see N.J.A.C. 10:69-3.28 and 3.30).

1. Whenever it is determined that a beneficiary family whose application has not been validated has changed or is planning to change its residence from one county to another, the CBOSS of origin shall continue assistance while completing the validation, subject to the time limits set forth in N.J.A.C. 10:69-2.15, then transfer the case without delay to the receiving county.
2. Whenever it is determined that a beneficiary family whose application has been validated is planning to change its residence from one county to another, it shall be the responsibility of the CBOSS directors of the two counties concerned to effect the transfer without interruption of Medicaid coverage.
3. The county of origin shall initiate and the receiving county shall, on request, immediately cooperate in accomplishing a full investigation of the circumstances

surrounding the move. If the move is permanent, each county shall execute its respective responsibilities in accordance with this paragraph.

i. The county of origin has the responsibility to:

(1) Transfer, within five working days from the date it is notified of the actual move, a copy of pertinent case material to the receiving county. Such material shall include, at a minimum, a copy of the first application and the most recent PA-1J form; the most recent 105A and B forms; Social Security numbers or copies of SS-5 forms; all birth verifications; and, where ongoing recovery of overpayments is involved, the amounts and net balances;

(2) Forward promptly to the receiving county copies of any other material mutually identified as necessary for case administration; and

(3) Instruct the client to contact the receiving county immediately to arrange for filing an application to transfer the Medicaid coverage.

ii. The receiving county has, except as noted in N.J.A.C. 10:69-7.6, the responsibility to:

(1) Communicate with the client if case material is received prior to client contact and the client's new address is known. Such communication shall invite the client to make application to ensure receipt of uninterrupted Medicaid coverage;

(2) Grant Medicaid coverage (provided application to transfer has been made) for the next month if initial case material has been received before the 10th of the month;

(3) Grant Medicaid coverage (provided application to transfer has been made) for the second month after the month of initial receipt of case records when such records are received on or after the 10th of the month; and

(4) Notify immediately the county of origin of the date case records were received and the date Medicaid coverage shall be granted.

iii. The welfare of the clients shall not be adversely affected and disagreement or other administrative difficulty between the counties shall not prejudice their right to uninterrupted Medicaid coverage. Any adverse action resulting from transfer requires timely notice (see N.J.A.C. 10:69- 6). If the receiving county is unable to verify eligibility within prescribed time limits, as stated in (b)3ii(2) or (3) above, it shall accept case responsibility in accordance with (b)3ii above and grant Medicaid coverage until such verification is completed (see N.J.A.C. 10:69-3).

iv. When a change in residence results in loss of Medicaid coverage, the receiving county shall send timely notice of such change to the client and a copy to the county of origin consistent with the requirements of N.J.A.C. 10:69-6. It is the receiving county's responsibility to send adverse notice, when necessary, after determining the client's circumstances following the change in county residence. In the event of a request for a fair hearing within 15 days of the mailing of such notice, the county of origin shall be notified and shall be responsible for Medicaid coverage pending the fair hearing.

1. Whenever the beneficiary is entitled to receive Medicaid until the final hearing decision, the county of origin shall issue the Medicaid card until the decision is rendered. The receiving county shall then immediately accept case responsibility and

issue the Medicaid card the next month, unless already issued by the county of origin.

(c) Those cases that are in Medicaid extension only shall also be transferred to the new county of residence when the family moves from the county of origin in the same manner as active AFDC-related Medicaid cases. The procedures established at N.J.A.C. 10:69-3.26(b) are to be followed when transferring a case in Medicaid extension (see also N.J.A.C. 10:69-8.22).

10:69-3.25 Verification of residence

(a) Verification of residence is necessary to ensure eligibility. Under some circumstances, documentary evidence of residence may not be available.

1. The following are examples of sources of evidence of residence:

i. Landlord's records and rent receipts;

ii. Public utility records and receipts;

iii. Personal property assessment records;

iv. Census records

v. Records of business or professional people such as grocers, bankers, and physicians with whom applicant has had frequent contact;

vi. Telephone directories;

vii. City directories if maintained on current basis;

viii. Postmarked letters addressed to applicant;

ix. Post office records;

x. School records;

xi. Records of social agencies, public or private;

xii. Employment records; or

xiii. Affidavits of knowledgeable persons which support other recorded evidence or knowledge of CBOSS.

10:69-3.26 Procedures governing release from State institutions

The procedures provided in this subchapter have been established specifically to govern relationships between the CBOSS and the several State institutions. These procedures do not necessarily apply to relationships with local mental hospitals and other institutions. When a CBOSS develops other procedures to expedite release of persons from local institutions, it shall submit complete plan material to the Division of Medical Assistance and Health Services for approval prior to granting Medicaid coverage to such persons.

10:69-3.27 Release from a State institution

(a) A parent or parent-person who is about to be released from an institutional facility (medical, mental, or correctional) may apply for AFDC-C related Medicaid.

(b) When eligibility has been established, benefits can begin upon release from the institution, providing the parent and child will be living together within 30 days of the date of issuance except in circumstances identified in (b)1 below. This application may be registered and processed up to two months before anticipated date of release.

1. When an applicant parent is being released from an institution for the mentally ill or retarded, a penal institution, or the New Jersey Neuro- Psychiatric Institute, no Medicaid card shall be issued until the actual release, discharge, or parole is a matter of record and verified by the CBOSS, and the applicant is not adjudged or alleged to be mentally incompetent.

(c) A parent or parent-person separated from a dependent child for a period no more than 30 days prior to application, who wishes to maintain an already established home for that child with whom such parent or parent-person customarily resides, may apply for and receive a Medicaid card for the child(ren) temporarily absent from the home. In this case, such parent or parent-person must indicate plans to return to the home within two months from the month in which the Medicaid card is initially issued (see N.J.A.C. 10:69-3.30 through 3.32).

(d) In the case of the return to the home of a beneficiary family by a parent, parent-person, or spouse in AFDC-C or child of eligible age in any segment, no application for Medicaid is involved.

1. If the individual will return to a home or plans to establish a home with a dependent child in the county receiving the inquiry and appears eligible for Medicaid, the CBOSS of that county shall register the application, assist in completion of the plan as necessary, complete the determination of eligibility and be responsible for issuance of the Medicaid card (see N.J.A.C. 10:69- 3.25(a)).

2. If the individual is to return to a home or desires to establish a home with a dependent child in another county, the CBOSS receiving the inquiry shall complete an application interview and assist the individual to complete an application form. All information that the applicant can supply shall be obtained and recorded on appropriate case record forms, which shall be forwarded to the county where the family currently resides or is planning to establish a home. The county receiving the application shall process and register the application without delay.

(e) Responsibility for initial planning for the return of a patient to the community rests with the institutional authorities. When AFDC-related Medicaid is necessary and the person appears eligible, the Division of Mental Health Services shall coordinate the application with the appropriate CBOSS. The Division of Mental Health Services shall be responsible for reviewing such referrals to assure that all essential information is assembled, and for expediting the processing of an application by the appropriate county board of social services for final determination of eligibility.

1. The institution shall routinely complete the following forms without change (a stock

supply of which shall be provided to them by the Division of Medical Assistance and Health Services) and shall forward copies to the CBOSS along with copies of staff notes pertinent to each case:

i. Form PA-12, Referral by State Mental Institution to AFDC-related Medicaid Agency; and

ii. Form DRS-8, Report of Findings by Psychiatric Diagnostic Group, where appropriate.

2. Persons under the jurisdiction of Division of Developmental Disabilities, Bureau of Field Services, shall be referred directly to the appropriate CBOSS.

(f) When a parent is about to be released from a veteran's hospital, the hospital shall make referral in writing, with the knowledge and consent of the veteran, to include the following minimum information: identifying data; the anticipated date of discharge; and a description of any known or tentative living arrangement following discharge;

1. In addition, the hospital shall complete, without charge, the following forms as appropriate;

i. DRS-8, Report of Findings by Diagnostic Group;

ii. Abstract of patient's hospital record, or in absence of abstract;

iii. DRS-1, Examining Physician's Report; and

iv. DRS-1A, Report of Eye Examination.

2. Thereafter, the county board of social services shall arrange for an application interview and shall process the application as any other.

(g) The social service staff of the institution shall assist in completing the application in accordance with N.J.A.C. 10:69-2.

1. The social service worker is responsible for prompt investigation to determine initial eligibility, including inquiry regarding any funds held by the institution or other party in a personal account for the applicant. The social service worker shall discuss available services including assistance in locating a suitable living arrangement with the applicant. The social service worker shall not send the completed referral forms to the designated CBOSS.

(h) The CBOSS shall register cases transferred from Division of Mental Health Services within one working day. The CBOSS shall determine initial eligibility within 30 days and so inform in writing the social service worker that will coordinate discharge of the client.

(i) A child of eligible age or a spouse of an AFDC-C beneficiary parent who is at home on extended visit or convalescent leave from a State institution is eligible for inclusion in the AFDC-C, -F or -N Medicaid eligible unit, as appropriate.

10:69-3.28 Temporary absence of a family member

(a) Eligibility for AFDC-related Medicaid may exist during the absence of a child, parent or parent-person from the home under the circumstances described in N.J.A.C. 10:69-3.31 and 3.32. When the absence is foreseeable, the CBOSS should make appropriate plans.

1. A parent or caretaker relative who fails to notify the county board of social services of the absence of the minor child from the home by the end of the five day period that begins with the date that it becomes clear to the parent or relative that the minor child shall be absent for more than 180 consecutive days shall be ineligible for benefits for a period of three months from the date the CBOSS becomes aware of the beneficiary's failure to notify the agency of the absence, which shall begin with the month following the month in which the absence becomes known.

10:69-3.29 Child or parent in an institution

(a) When a child who would be otherwise eligible for AFDC-related Medicaid is out of the home due to voluntary/involuntary placement in an institution, he or she shall be recognized as a member of the eligible unit so long as it is anticipated that he or she will return home within one year from the date of the placement. State only funds shall be used after the minor child has been absent from the home for more than 180 consecutive days.

1. A child whose placement is specified for a period longer than one year shall not be eligible during the entire period of placement. (See N.J.A.C. 10:69-11.5 regarding visits home of seven or more days.)

2. Placement for an unspecified or indeterminate period shall be construed to be for less than one year. Should such period extend beyond one year, the child shall be deleted from the eligible unit at the end of the year.

3. In the case of a new application, eligibility of an institutionalized child shall be based on the specified length of the placement starting from the date the placement began.

(b) The term "parent" as used in (c) below includes both parents and parent- persons.

(c) Rules concerning a parent in an institution are:

1. In AFDC-C, when a parent is absent for diagnostic treatment or care and, even though hospitalized, is able to retain responsibility for supervising a plan for adequate care and control of his or her child(ren), eligibility shall continue so long as necessary to complete recovery but not to exceed three months.

i. When it appears that the absence will continue for more than three months, the case shall be reevaluated relative to the care and protection of the children and approval of the Division of Medical Assistance and Health Services obtained for continued eligibility of the parent.

2. In AFDC-F and -N cases, when a parent is absent from the home due to one of the

following conditions, the case shall be immediately reviewed for transfer to AFDC-C if:

i. A parent is hospitalized and such condition will continue for at least 30 days; or

ii. A parent is committed to an institution and such absence will continue for at least 30 days.

10:69-3.30 Absence for reasons other than institutional

(a) Temporary absence of a child which has not lasted more than 30 consecutive days does not affect eligibility. When the absence of a child lasts longer than 30 days or it appears that an absence will last longer than 30 days, the CBOSS shall review the situation.

1. If it is found that the parent or parent person lacks or will lack both physical custody and responsibility for day to day care of the child and the situation is likely to continue for more than 90 days, the child is no longer eligible for Medicaid coverage. In situations in which the whereabouts of the child is unknown, or the parent or parent-person is precluded from contact, or the time period is otherwise indefinite, the child is no longer eligible for Medicaid coverage.

2. If it is found there is reasonable expectation that the child will return to the home within 90 days, the child remains eligible.

3. The child remains eligible during the time that the review under (a) above is in process, but not longer than 90 days.

4. In unusual situations involving particular hardship, the CBOSS may consult with the Division of Medical Assistance and Health Services.

(b) Regarding parent or parent-person, temporary absence of not more than 30 days for whatever reason shall not affect eligibility provided that adequate care and supervision of the child(ren) has been arranged in advance. When necessary, arrangements shall be made by the county board of social services regarding changing the receiver of the Medicaid card.

1. The county board of social services shall obtain approval from the Division of Medical Assistance and Health Services for continuing eligibility in unusual situations of temporary absence lasting more than 30 days.

(c) When the entire family unit leaves the State for a temporary visit, the provisions of N.J.A.C. 10:69-3.21 through 3.22 shall apply.

10:69-3.31 Legally responsible relatives (LRRs)

(a) Certain relatives are legally considered responsible to provide support if financially able and may be a source of income for an AFDC-related Medicaid applicant or beneficiary. The CBOSS shall determine the capacity of LRRs to contribute to the support of AFDC-related Medicaid applicants and beneficiaries.

(b) The county board of social services director is authorized under specified

circumstances to apply to the appropriate court for a support order. In cases where a court order appears to be the only means of insuring consistent and actual support, the applicant/beneficiary may elect to receive from the CBOSS the grant for which he or she is eligible and request the CBOSS to collect the support payments. (See N.J.A.C. 10:69-3.36.) The applicant shall be fully informed of these provisions and their impact:

1. The following chart identifies relatives who are recognized as legally responsible under AFDC-related Medicaid:

Legally Responsible Relative	AFDC-related Medicaid Program
Spouse	X
Child under age 55	X
Parent of a child under 18 or of a child over age 18 who is not an AFDC-related Medicaid parent or parent-person	X

(c) All legally responsible relatives shall be contacted in completing the investigation:

1. Regardless of where the relative lives, it is the responsibility of the eligibility worker to obtain the necessary information by the most direct and practical method.

i. The legally responsible relative shall be the primary source of the information required to evaluate his or her capacity to support.

ii. When the evidence submitted by the relative is inadequate or shows a discrepancy, or he or she is unable to submit evidence, he or she shall understand that it shall be necessary for the agency to obtain verification directly from his or her employer, bank and so forth.

(d) Legally responsible relatives shall be reevaluated at least once every 12 months. See N.J.A.C. 10:69-5.3 regarding reevaluation and situations in which contact need not be made.

(e) Priorities of obligations to support legally responsible relative are:

1. A person's obligation to support those relatives for whom he or she is legally responsible takes precedence over voluntarily assumed obligations.

2. Responsibility of a person for the support of his or her own minor children takes priority over any obligations for other relatives.

(f) The eligible unit shall not be eligible for AFDC-related Medicaid when the amount of the legally responsible relative's evaluated capacity to support equals or exceeds their adjusted allowance and this support is actually provided to the eligible unit.

1. The LRR's contribution shall be considered available only when there is affirmative and persuasive evidence that such amount or its equivalent in goods or services is in fact provided to members of the eligible unit. (For details see N.J.A.C. 10:69-3.7.)

2. When any LRR fails or refuses to provide any portion of his or her contribution the agency shall, within 30 days, take appropriate action in accordance with available procedures to compel contribution in the amount of the adjusted allowance or the evaluated capacity to support, whichever is less.

3. Whenever the LRR fails or refuses to furnish information concerning his or her ability to support members of the eligible unit, it shall be deemed a failure or refusal to provide support as required by law.

i. In such cases the agency shall take appropriate action within 30 days, in accordance with available procedure to secure judicial determination of the LRR's ability to support the eligible unit member(s). Until such determination is made, each LRR shall be considered a potential resource.

4. For a LRR in the home of the eligible unit, see N.J.A.C. 10:69-3.10(b) 5.

(g) When it has been determined by judicial process that a child of an applicant for or beneficiary of AFDC-related Medicaid has been abandoned, deserted or not supported by the applicant or beneficiary during his or her minority, such person is legally excused and relieved of obligation and shall not be considered a legally responsible relative.

(h) When an individual (under the age of 19) who is himself or herself a parent lives in the same home as his or her own parent(s) or legal guardian(s), and the adolescent parent applies for AFDC-C or -F, the income of such parent(s) or legal guardian(s) shall be considered available to the eligible unit in accordance with the deeming provisions of N.J.A.C. 10:69-10.45 and 10.46.

10:69-3.32 Support orders for legally responsible relatives

(a) The county board of social services director has authority, after due investigation, to direct a legally responsible relative to pay toward the support of an applicant for or beneficiary of AFDC-related Medicaid.

(b) Upon failure of such relative to comply, the director shall so certify in writing to the county court or to the court of juvenile and domestic relations of the county, whereupon such court may, after hearing, "order and adjudge the able relative or other persons responsible for the support of such applicant to pay such sum or to deliver to the court or to the County Board of Social Services director such other pledge or guaranty as the circumstances may require in the discretion of the court for each such applicant."

(c) The county board of social services may also bring appropriate action in a court of competent jurisdiction to recover any sum of money due for Medicaid coverage given any person under this chapter against any person chargeable by law for the support of such persons.

(d) Where the relative from whom support is sought is a resident of another state and

the county board of social services is unsuccessful in securing information and/or voluntary contributions commensurate with the evaluated capacity to support, either by direct correspondence or through an appropriate AFDC-related Medicaid agency, the procedures provided in the Uniform Reciprocal Enforcement of Support Act, N.J.S.A. 2A:4-30.24 et seq., shall apply.

(e) When there is evidence that a relative is failing to comply with the order of the county board of social services director, the director shall follow the legal procedure as provided in (b) above. Where there is failure to comply with the order of a court, the county board of social services shall consult with the probation department or with the court that placed the order.

(f) With respect to AFDC-C segment, it shall be recognized that the presence of a stepparent in the home does not relieve either natural parent of duty to support a child.

(g) An order to support should not be sought against a reputed father of a child born of unmarried parents until paternity has been judicially established.

(h) The following concern the inability of a legally responsible relative to comply with an order:

1. Where there is evidence that a relative is not able or no longer able to comply with the order of the director, there shall be prompt reevaluation of capacity to support, and the order shall be voided or the amount adjusted, as appropriate.
2. Where such situation is found to exist in respect to a relative under court order to support, the terms of the order cannot be changed except by amendment by the court itself after review. The county board of social services will assist in initiating amendment proceedings in such cases.

(i) Where the amount of support actually received, under court order and otherwise, exceeds the per capita share of the income standard for the family size for the individual for whose benefit it is paid, the client shall be informed of the right to choose whether to leave the eligible unit and have the benefit of all the income or to remain in the eligible unit. All consequences including those with regard to Medicaid shall be clearly and explicitly explained. This provision also applies to other legally designated income. (See N.J.A.C. 10:69-11.17.)

10:69-3.33 (Reserved)

10:69-3.34 Liquidation of all debts, claims, interests, settlements, and trust funds

(a) Members of the eligible family shall take all necessary and reasonable action to avail themselves of funds for support from others who owe or may owe money to them

or who are holding funds for them. Any funds made available by such action shall be considered as income to the eligible family, except as provided in N.J.A.C. 10:69-3.36(b).

1. When a trust fund exists for a member of the eligible family, the CBOSS shall determine whether or not the funds are currently accessible. If accessible, the funds represent a source of funds for support and shall be considered in determining eligibility.

i. When a trust fund is not currently accessible and it exists at the time of application, the client shall, as a condition of eligibility, make a bona fide presentation of a petition to the appropriate court for release of the funds for current and future support. The agency shall assist the client if necessary.

(1) When a trust fund is not currently accessible and came into being during the term of the assistance case, the agency shall present a petition to the appropriate court for release of funds for current and future support. The client shall, as a condition of continuing eligibility, provide whatever cooperation may be necessary in the presentation of the petition.

10:69-3.35 Repayment

(a) The CBOSS shall, in all circumstances, take appropriate action to recover all AFDC-related Medicaid improperly granted. The action taken shall be in accordance with the appropriate sections of this chapter, N.J.A.C. 10:49 and any other applicable authority.

1. Recoveries of funds applicable to more than one CBOSS shall be divided according to the mutual agreement of the directors of the CBOSSs involved.

(b) Properly granted AFDC-related Medicaid coverage rules are as follows:

1. Repayment of Medicaid coverage in the AFDC-related Medicaid program (all segments) is required in certain cases in which Medicaid coverage is provided for treatment where another third party is responsible for payment of the medical services. Medicaid coverage is granted while the beneficiary(s) awaits receipt of funds from some other source. See N.J.A.C. 10:69-3.40 for rules on liquidation of non-exempt real property. See N.J.A.C. 10:69- 3.39 regarding repayment following liquidation of other pending claims.

(c) Rules when agreement to repay is not required are as follows:

1. Agreements to Repay are not to be used in any Medicaid program.

2. Upon signing an application for AFDC-related Medicaid (PA-1J), the applicant or beneficiary automatically assigns all support rights (whether for past due or future support) to the CBOSS. The signing of an Agreement to Repay is therefore not required when the pending payment arises from potential entitlement to payment of support from a relative.

10:69-3.36 Action by CBOSS upon voluntary liquidation

(a) Upon voluntary liquidation of a claim or interest, and the family is currently receiving AFDC-related Medicaid, the CBOSS shall evaluate the situation to determine the family's continued eligibility for Medicaid coverage.

(b) Rules on continued eligibility arising from sale of exempt resources (see N.J.A.C. 10:69-12.2 for exempt resources) are as follows:

1. The CBOSS shall not terminate eligibility when the proceeds from the sale of an exempt resource are promptly reinvested in another exempt resource of the same type. Funds designated by the client as being reserved for such reinvestment, including any interest accrued during the period, may be held for up to three months, provided the funds are held in escrow or are otherwise unavailable for daily living expenses. The three-month period may be extended upon written approval of the Division of Medical Assistance and Health Services.

10:69-3.37 (Reserved)

10:69-3.38 Strikers

(a) AFDC-related Medicaid benefits shall not be payable for any month in which any caretaker relative with whom the child is living, is, on the last day of such month, participating in a strike. Additionally, no individual's needs shall be included in determining the amount of AFDC-related Medicaid payable for any month to a family if, on the last day of the month, such individual is participating in a strike.

1. The term "strike" includes any strike or other concerted stoppage of work by employees (including a stoppage by reason of expiration of a collective bargaining agreement) and any concerted interruption of operations by employees.

2. The term "participating in a strike" means an actual refusal in concert with others to provide services to one's employers.

END OF SUBCHAPTER 3

SUBCHAPTER 4. MEDICAID SPECIAL

10:69-4.1 General provisions

(a) An individual under age 21, who would not have qualified as a dependent child for AFDC-related Medicaid, whether or not he or she lives with his or her parent(s), may be eligible for Medicaid Special.

1. An individual under age 21 who would not have qualified as a dependent child for AFDC-related Medicaid shall be evaluated for Medicaid Special in accordance with this subchapter, but without regard to income or resources, if that individual was, at age 18, in foster placement under the supervision of the Division of Youth and Family Services with his or her maintenance paid in whole or in part from public funds. Such individual shall be eligible for medical coverage up to the age of 21.

(b) When the individual lives in the same household as his or her birth or adoptive parent(s), financial eligibility shall in all cases include the parent's(s') income. If applicable, the deemed income of the stepparent shall be included. For the determination of financial eligibility of an individual under the age of 21, he or she shall be considered to be in an eligible family consisting of the applicant, his or her parent(s) and the parent(s) dependent children.

(c) When an individual does not live with his or her birth or adoptive parent(s), eligibility shall be determined for an eligible family of one, considering only the individual's income (see N.J.A.C. 10:69-4.1(c) regarding LRRs).

1. If the individual is married and living with his or her spouse, they shall be considered an eligible family of two and all income of both parties shall be considered.

(d) Rules concerning pregnant women under age 21 are as follows:

1. Medicaid Special may be provided to a pregnant woman under age 21 if the pregnant woman meets all the Medicaid Special requirements as set forth in this chapter.

2. Eligibility is determined for an eligible family of two, or more if a multiple pregnancy (woman and unborn children), based on her income only, or, if she is married and living with her spouse, on an eligible family of three or more (woman, spouse and unborn children) including income of both spouses. Medicaid coverage does not include the spouse even though his income is included in the eligibility determination.

i. The income and household size provision at (d)2 above cannot be used prior to the date it was medically determined the woman became pregnant.

ii. A pregnant woman with other dependent children should be assisted in making immediate application for AFDC-related Medicaid based on AFDC rules in effect as of July 16, 1996 and for TANF cash assistance. If she is found ineligible under AFDC-related Medicaid rules, the CBOSS shall determine potential eligibility for New Jersey Care ... Special Medicaid Programs coverage for pregnant women (see N.J.A.C. 10:72).

iii. After the birth of the child, so long as the mother was eligible for and receiving Medicaid Special benefits at the time of the birth of the child(ren), and the child(ren) resides with her, the child(ren) remains eligible for Medicaid for period of one year, whether or not application has been made.

10:69-4.2 Determination of eligibility; Medicaid Special

(a) All appropriate rules in this chapter regarding income shall apply in determining financial eligibility. Requirements related to employment or training or job search activities, school attendance of a child, the birth of additional children, and parent minors not residing with specified applicants/beneficiaries are not applicable in the determination of eligibility for Medicaid Special. Sanctions relating to the Child Support and Paternity program shall not be imposed on applicants for Medicaid Special.

(b) Earned income shall be calculated in accordance with AFDC-C and -F procedures found in this chapter.

1. Work First New Jersey/GA payments whether in the form of cash, check or assistance order or a combination of the above shall be countable as income for purposes of determining eligibility for Medicaid Special. If the individual is ineligible for Medicaid Special due to this income, he or she shall be evaluated for the Medically Needy Program as a child or if disability is alleged, for New Jersey Care ... Special Medicaid Programs.

(c) Obligations of LRRs who live in the same household as the applicant/beneficiary are accounted for in the eligibility determination process. No further evaluation or pursuit of contributions from such LRRs is required. Actual contributions from parents outside the household shall be considered in all eligibility determinations but pursuit of non-voluntary contributions from parents outside the household shall be made only by or on behalf of applicant/beneficiaries under the age of 18. Contributions from a spouse outside the household shall be sought in all cases.

(d) Medicaid Special is available only for U.S. citizens or eligible aliens. (See N.J.A.C. 10:69-3.9 requirements related to alien status.)

(e) Eligibility for Medicaid Special does not include eligibility for burial expenses, nor do the Medicaid extension benefits apply.

10:69-4.3 College students and Medicaid Special

(a) A student's permanent residence is considered to be with his or her parents even though he or she is temporarily absent to attend college. A student shall be determined "not living with parents" only when the CBOSS has verified that all of the following conditions exist:

1. The student lives apart from his or her parents for reasons other than convenience

of attending school;

2. His or her parents do not provide one-half or more of his or her support; and

3. His or her parents did not claim the student as an exemption on their most recent Federal income tax return or they affirm that the student will not be claimed on their next return.

(b) Eligibility shall be determined on a semester basis inclusive of vacations during such semester. When a student is not actually attending college classes during other periods, such as summer vacations or other breaks of one month or more, a separate eligibility determination shall be required based on current circumstances.

(c) Income from all sources shall be applied in determining eligibility of college students not living with his or her parent(s), except that educational loans and grants shall be treated in accordance with N.J.A.C. 10:69-10.8. All earnings of the student shall be considered for purposes of Medicaid Special (see N.J.A.C. 10:69-4.2(b)).

(d) See N.J.A.C. 10:69-4.2 for other factors relating to eligibility.

END OF SUBCHAPTER 4

SUBCHAPTER 5. CONTINUING ELIGIBILITY IN AFDC-RELATED MEDICAID

10:69-5.1 Continuing eligibility defined

(a) The eligibility of each case shall be redetermined at regular intervals.

(b) The eligibility worker shall be alert to indications of change in need for financial assistance or change in circumstances that may affect the eligible unit's continuing Medicaid eligibility.

10:69-5.2 Requirements for periodic redetermination

(a) Redetermination is a review of factors affecting AFDC-related Medicaid eligibility, including, but not limited to, continued parental deprivation, or changes in income. At the redetermination, the parent(s) shall complete an application for continuation for Medicaid. If a redetermination is not conducted and the CBOSS is responsible, the right of the client to continued Medicaid shall not be jeopardized.

(b) For beneficiaries of AFDC-related Medicaid, all factors of eligibility shall be redetermined at least every 12 months. No case shall be terminated before evaluating eligibility, using data available from other sources, such as the Food Stamp or Work First programs. All cases determined ineligible for AFDC-Medicaid shall be screened for eligibility under all other program options. Referrals shall be coordinated to ensure that continuous coverage of benefits is available to the beneficiary, as applicable.

(c) Redeterminations shall be conducted in each case at least once every 12 months, but, at the beneficiary's option, the beneficiary may mail in the redetermination form to the CBOSS.

(d) It is the responsibility of the CBOSS to maintain a control file to assure that redeterminations are undertaken and acted upon at intervals as prescribed by this section. The redetermination time interval shall be contingent upon the month in which an initial Medicaid card is issued, rather than on such factors as the date of application or final validation of eligibility. For example, an AFDC-related Medicaid case receiving an initial Medicaid card in July shall have a redetermination completed prior to the January card issuance so that the effective date of the redetermination shall be January 1.

10:69-5.3 Process of redetermination

(a) Beneficiaries shall be personally interviewed regarding the application for continuation of Medicaid. The eligibility worker shall assist the beneficiary in the completion of the application form, providing explanation as necessary. If the beneficiary cannot read, the contents of the form shall be read to him or her. Upon request, the client shall be given a copy of his or her executed application form, with any

attachments. Signature requirements shall be the same as for initial application. The contact shall focus on discussion of the eligibility factors, which are subject to change and shall include information about any change in agency policy or procedure that affects the beneficiary's status. There shall also be a reevaluation of the family's need for social services. When the parent is represented by a protective payee or has a representative payee, such person shall also be interviewed. A summary report including all pertinent information shall be made for each contact with the parent(s), parent-person(s) or collateral sources.

(b) In each redetermination, it is the responsibility of the eligibility worker to complete the appropriate forms.

1. When there is a pending claim, the appropriate procedure in N.J.A.C. 10:69-3.35 shall be followed.

(c) Attention shall be given to any change in residence that may affect county responsibility.

(d) Eligibility with respect to age and school attendance shall be evaluated for a child who is nearing the age beyond which he or she is no longer eligible. The eligibility of the family shall be evaluated when the youngest child is nearing the age and school situation beyond which he or she will no longer be eligible.

10:69-5.4 Competency status in AFDC-related Medicaid

(a) The eligibility worker should be alert to the development of medical or mental problems that may affect the adequate functioning of the parent. Such evidence shall be submitted to the Disability Review Section for special review.

(b) If it is the finding of the CBOSS that the parent or parent-person has demonstrated such inability to manage the medical care of the child, the Medicaid card can be issued to a third party. In such cases, the client shall be fully advised of his or her rights.

10:69-5.5 Institutional status in AFDC-related Medicaid

Upon the parent's(s') or parent-person's(s') admission to an institution, the eligibility worker should be alert to the initiation of "temporary payee" as provided in N.J.A.C. 10:69-4.7.

10:69-5.6 Requirements with respect to deprivation of parental support or care in AFDC-C

(a) Since eligibility in AFDC-C is based on the fact that the needy child has been deprived of parental support or care by reason of the death, continued absence from home, or mental or physical incapacity of a natural or adoptive parent, it is necessary to reevaluate these factors in determining continuing eligibility. A family may continue to

be eligible for AFDC-C although the original reason for "deprivation" has changed. This may occur when an absent parent dies or, although returned to the home, is incapacitated. Such change in status shall be appropriately noted in the case record.

(b) When eligibility is based on deprivation of parental support or care by reason of the continued absence of a parent, the evaluation of continued eligibility shall include a determination that the absence still exists and, if not, whether there is another basis for eligibility.

(c) The following concern incapacity status for a natural or adoptive parent:

1. There shall be redetermination that "incapacity" exists in every case in which the eligibility of the family is based on the incapacity of a natural or adoptive parent.

2. The Disability Review Section, Division of Medical Assistance and Health Services shall designate the review date for the CBOSS. "Incapacity" shall be considered as continuing until the Disability Review Section officially determines that such incapacity no longer exists. The eligibility worker shall prepare Form DRS-2A, Interim Medical-Social Report, for the redetermination review. The CBOSS shall maintain controls on review dates so that any specific medical information or reports requested by the Disability Review Section may be obtained. In addition, the Disability Review Section shall maintain a control file in order to ensure appropriate and timely reevaluation by that Section. The Disability Review Section will notify county boards of social services one month in advance of cases scheduled for such review by means of Form DRS-5.

3. In any case in which, subsequent to a finding of "approved," the incapacitated parent becomes a beneficiary of Federal disability benefits or SSI benefits for reasons other than age, this of itself shall be considered conclusive proof of continuing incapacity, and the CBOSS shall disregard the "review date" for submittal to the Disability Review Section.

4. It is the responsibility of the eligibility worker to submit the record to the Disability Review Section for special review if available evidence raises question of continuing incapacity during the interval between redetermination review dates. The special review shall be requested through use of Form DRS-2A, Interim Medical-Social Report, together with all material previously submitted.

(d) When, subsequent to a finding of "approved" on the "incapacity" factor, the CBOSS learns that the parent has obtained full-time employment at normal rate of pay for a job appropriate to his or her capacity, then incapacity no longer exists.

(e) The following concern when an "incapacitated" natural or adoptive parent is in institution:

1. In cases where AFDC-C has been granted on the basis that a natural or adoptive parent will be receiving care for a physical or mental illness in a public or private institution, it shall be necessary for the eligibility worker to check periodically with the

family, and in some cases with the institution, regarding the incapacitated parent's progress and discharge.

2. As soon as the date of discharge is known, or if the CBOSS learns that the parent has already been discharged to his or her home, the CBOSS shall submit the required record material to the Disability Review Section as appropriate to the situation; that is, if official determination of incapacity had already been made, the previous record shall be submitted for review with a completed Form DRS-2A; if the case had not been previously submitted, then a DRS-2 giving current situation and Form DRS-1 (Examining Physician's Report) shall be submitted. Whenever practical, the DRS-1 form should be prepared by a staff physician of the institution.

3. An abstract of the hospital record may be accepted in place of Form DRS- 1, when the parent is in the hospital or has been released within the past three months. The client's consent in writing for release of the information shall accompany the request.

10:69-5.7 Marriage or remarriage

In AFDC-C, when eligibility is based on the absence of one parent and the remaining parent marries or remarries, such marriage or remarriage does not in and of itself terminate eligibility but does require prompt redetermination of financial need and eligible unit composition in accordance with N.J.A.C. 10:69-10.33 or 10.34, as applicable.

10:69-5.8 Special conditions relating to parent(s) in AFDC-F and -N

(a) When a parent becomes absent from the home and continuous absence is established (N.J.A.C. 10:69-2.8(e)), the AFDC-F or -N case shall be transferred to the AFDC-C segment. No interruption of Medicaid shall result if AFDC-C eligibility begins with the absence.

(b) When a parent becomes hospitalized, incapacitated, committed to a mental institution or incarcerated in a penal institution and the CBOSS has evidence that this condition will continue beyond 30 days, the case shall be transferred to the AFDC-C segment. No interruption of Medicaid shall result if AFDC- related Medicaid eligibility begins with such aforementioned situation.

10:69-5.9 Legally responsible relatives capacity to support

(a) Each legally responsible relative's capacity to support shall be reevaluated at least once in each 12-month period and adjustments made as indicated (see N.J.A.C. 10:69-3.31(d)).

(b) Each legally responsible relative shall be contacted unless it can be verified that the relative:

1. Is receiving public or private financial assistance;
2. Has no source of support except fixed income, such as pension, retirement benefits

or statutory benefits, and there was no capacity to support at time of last evaluation;

3. Is himself or herself dependent upon a relative (other than the client) for support;

4. Is receiving care in an institution for a mental or physical condition, or is in a penal institution and has no capacity to support; or

5. Cannot reasonably be anticipated to have experienced a change in income since the last evaluation that would affect his or her capacity to support. (The eligibility worker will consult with his or her supervisor when this appears to be the situation.)

(c) When a decision is made that it is not necessary to reevaluate capacity to support for one of the reasons in (b) above, the justification for such decision shall be recorded in the case record with notation of any plan for making contact in the future.

(d) The CBOSS shall avoid making routine requests of other county boards of social services or of out-of-State agencies to contact relatives for reevaluation of capacity to support. When, after careful evaluation of the need for such service, it is considered essential to request an interview, the letter of request shall clearly identify both the nature and the purpose of the desired service.

10:69-5.10 Recording and recommendation for changes in AFDC-related Medicaid eligibility

A complete summary report of pertinent information shall be made for each contact with a beneficiary, which shall clearly state the basis for any recommendation for termination of Medicaid. A new redetermination form shall be completed for each redetermination.

10:69-5.11 Notice of agency decision

(a) Each applicant shall receive timely and adequate written notice of any change in Medicaid eligibility status in accordance with N.J.A.C. 10:69-6.

(b) If the notice of intention to terminate Medicaid eligibility is related to identification of possible fraud, beneficiaries are entitled to:

1. Timely notice in certain cases of probable fraud (see N.J.A.C. 10:69- 3.39 through 3.44); and

2. Seven days notice shall be considered timely when, in the judgment of CBOSS director, there is substantiated evidence that client is receiving Medicaid coverage through willful fraud (see N.J.A.C. 10:69-9.15 through 9.18).

10:69-5.12 Periodic notice to client

(a) The client shall be informed periodically (at least once every 12 months) of his or her continuing obligation to furnish accurate and timely information to the CBOSS concerning changes in income or other circumstances which may affect the receipt of benefits. The applicant shall receive, and have explained if necessary, a copy of the

pamphlet Medicaid Rights and Responsibilities. This pamphlet shall be given to the applicant at the time of application and at each redetermination if the beneficiary has not retained the copy previously provided. The client shall inform the CBOSS of any change as soon as possible but in no event later than two weeks after the change takes place. Failure of the client to so inform the CBOSS shall constitute willful withholding of information.

(b) The client, by the signing of an affidavit, agrees that he or she has received the pamphlet, has been informed of his or her rights and obligations as stated in the pamphlet, and understands them.

10:69-5.13 Extension of Medicaid benefits

(a) Extended Medicaid benefits shall be provided former AFDC-related Medicaid families in accordance with the provisions of this section for a period of 24 months beginning with the month in which the family would have no longer have otherwise been eligible for AFDC-related Medicaid due to an increase in earned income.

1. When an AFDC-C,-F or-N family loses eligibility for AFDC-related Medicaid due to the following reasons, Medicaid eligibility continues for a period of 24 months beginning with the month in which the family is no longer eligible for AFDC-related Medicaid:

i. Earnings or increased earnings from employment, including earnings from new employment;

ii. Increased hours of employment; or

iii. Receipt of New Jersey State unemployment or temporary disability insurance benefits.

2. New members added to the eligible family during the 24 month extension period, as appropriate, are not included under the extended coverage, with the exception of a child born to the family during the 24 month extension period. For children born during this period, the child and the mother may be eligible for additional coverage if the 60-day post-partum period continues beyond the termination of the extension period applicable to the remainder of the household, or if the child's 12-month guaranteed period of Medicaid eligibility continues beyond that termination date. In either case, Medicaid eligibility terminates at the end of the guaranteed eligibility period, if that termination date is later than the termination date of the 24 month Medicaid extension.

3. Eligibility for the 24-month Medicaid extension is not available for any month to any individual who, except for income or hours of employment, is not otherwise eligible to receive AFDC-related Medicaid. The following individuals shall not be included in the eligible family for Medicaid extension:

i. Any child who reaches the age of 18, or any child who is attending a secondary or vocational school full-time up to the month of graduation or age 19, except that such child shall be evaluated for Medicaid eligibility for other appropriate Medicaid programs; and

ii. All other family members who are receiving Medicaid extension solely because of

the presence in the home of a child who "ages out," as in (a)3i above.

4. When an AFDC-C related Medicaid family loses eligibility as a result (wholly or in part) of the collection of child or spousal support through the Child Support and Paternity process, AFDC-related Medicaid eligibility continues for a period of four calendar months beginning with the month in which such ineligibility begins.

i. In order to qualify for this extension of Medicaid benefits, the family must have received and been eligible to receive AFDC-C-related Medicaid in at least three of the six months immediately preceding the month in which ineligibility for AFDC-related Medicaid begins;

ii. Eligibility for this extension shall be terminated for any child who reaches the age of 18, or any child who is attending a secondary or vocational school full-time up to the month of graduation or age 19, except that such child shall be evaluated for Medicaid eligibility for other appropriate Medicaid programs; and

iii. All other family members who are receiving Medicaid extension solely because of the presence in the home of a child who "ages out," as described in (a)4ii above, shall be terminated.

(b) Those cases which are in Medicaid extension only shall also be transferred to the new county of residence when the family moves from the county of origin in the same manner as active AFDC-related Medicaid cases. The procedures established at N.J.A.C. 10:69-3.27(b) are to be followed when transferring a case in Medicaid extension.

(c) AFDC applicants may be eligible for retroactive Medicaid benefits; such determinations are made by DMAHS. The eligibility worker shall ask if the family has unpaid medical bills from the previous three months and shall provide the applicant with appropriate forms. The Division of Medical Assistance and Health Services shall make a determination of eligibility for each of the three previous months, based on the eligibility rules in this chapter.

(d) AFDC eligible families who would not have received any AFDC payments solely because the amount payable would be less than $10.00, are eligible for AFDC-related Medicaid benefits. Likewise, AFDC families who would have been ineligible for AFDC solely because of rounding of the amount that would otherwise be payable, are eligible for AFDC-related Medicaid benefits.

(e) For newborns of eligible women who have applied (before or on the date of the birth) and are eligible for Medicaid on the date of birth (except for a presumptively eligible pregnant woman, as defined at N.J.A.C. 10:72-6.1, who is subsequently found ineligible for the month the child was born), eligibility continues for both mother and child through the last day of the month in which the 60-day post-partum period ends, without regard to other program requirements. So long as the mother remains eligible, or would

remain eligible if pregnant, and the child resides with her, the child remains eligible for Medicaid for a period of one year, whether or not application has been made for the child.

(f) Individuals who were admitted to a hospital and were subsequently referred to the CBOSS through the use of Form PA-1C, Public Assistance Inquiry, may be eligible for Medicaid benefits from the date the PA-1C was completed, provided:

1. Such individual was an inpatient at the time the referral was made;
2. Except for good cause, including, but not limited to, hospitalizations lasting for three or more months, the homebound status of the applicant, the CBOSS was unable to schedule a timely application appointment, or the hospital failed to inform the applicant to apply at the CBOSS, the individual applies for AFDC-related Medicaid benefits within three months after the referral is made.

i. If the CBOSS determines that the individual had good cause for not applying within three months, an extension may be granted for an additional three months.

ii. Newborns of eligible women are deemed to have applied and shall be added to the Medicaid case, effective the date of birth, upon receipt of a valid Form PA-1C (see N.J.A.C. 10:69-8.10(e) for coverage limits).

(g) Those cases which are in Medicaid extension only shall also be transferred to the new county of residence when the family moves from the county of origin in the same manner as active AFDC-related Medicaid cases. The procedures established at N.J.A.C. 10:69-3.27(b) are to be followed when transferring a case in Medicaid extension.

10:69-5.14 Change in eligible unit

(a) A newborn child shall be added to the AFDC-related Medicaid case effective with the date of birth, provided that the CBOSS is notified within one year of that date.

(b) The date of change for adding other members added to an eligible unit shall be the first day of the month the eligible unit reports to the CBOSS the addition of the member.

END OF SUBCHAPTER 5

SUBCHAPTER 6. COMPAINTS, HEARINGS AND ADMINISTRATIVE REVIEWS

10:69-6.1 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise.

"Adequate notice" means a written notice that meets the requirements of N.J.A.C. 10:69-6.3

"Administrative hearings" are hearings concerning either contested cases or non-contested cases, which have been determined by the Director of the Division of Medical Assistance and Health Services (DMAHS) in accordance with N.J.A.C. 1:1-1, to be appropriately heard in the Office of Administrative Law (see N.J.A.C. 10:6).

"Administrative law judge" (ALJ) means the person from the Office of Administrative Law (OAL) who conducts the hearing and who writes an initial decision which may be reviewed by the Director of the Division of Medical Assistance and Health Services.

"Administrative review" means a review of a disputed matter which has been determined by the Director of the Division of Medical Assistance and Health Services not to constitute a contested case and therefore remains in the Division for review. At the discretion of the Director, an administrative review may be conducted as a procedure at which parties appear and are heard or it may be a paper review. (See N.J.A.C. 10:69-1.2.)

"Administrative review official" is a representative of the State, Department of Human Services assigned to conduct an administrative review.

"Adverse action" means any action by a CBOSS resulting in denial of application for AFDC-related Medicaid. An adverse action is an action to deny an application for Medicaid, or to terminate Medicaid (including service, vendor payments or Medicaid entitlement) or to deny payment to a vendor for medical services required to be reimbursed by the county board of social services.

"CFR" is the acronym for Code of Federal Regulations.

"Contested case" means a dispute that is heard by an Administrative Law Judge.

"Fair hearing" means a formal or informal procedure through which a AFDC- related Medicaid client may protest an adverse action or decision of the county board of social services (CBOSS) regarding eligibility or manner of granting AFDC-related Medicaid. Fair hearing is a general term which includes administrative hearing and administrative

review.

"Initial decision" means the decision of an administrative law judge that is sent to the Director of the Division of Medical Assistance and Health Services, who may accept, reject or modify it within 45 days.

"Timely notice" means that the notice is mailed at least 10 days before the effective date of agency action.

10:69-6.2 Right to fair hearing and administrative review

(a) It is the right of every applicant or beneficiary adversely affected by an action by a county board of social services (CBOSS) to be afforded a fair hearing in a manner established by the rules in this subchapter and by the Uniform Administrative Procedure Rules (N.J.A.C. 1:1). These rules have been established pursuant to Federal regulations (45 CFR 205.10) and the New Jersey Administrative Procedure Act (N.J.S.A. 52:14B-1 et seq.).

(b) The county board of social services shall promptly notify the beneficiary in writing of any agency decision affecting that client. The term "agency decision" refers to a decision made by the county board of social services and includes any decision made by the county board of social services. In the case of a client who cannot be located, notice shall be sent to his or her last known address.

(c) Agency action which adversely affects an applicant or beneficiary includes:

1. Any action, inaction, refusal of action, or unduly delayed action with respect to program eligibility, including, but not limited to, denial or termination of benefits; and
2. When the complete processing of an application is delayed beyond 30 days, the applicant is to be notified of this fact and the reason(s) for the delay on or before the expiration of such period (see N.J.A.C. 10:69-2.14 and 2.15).

(d) The written notice of adverse action shall, at a minimum, include the following:

1. The action the agency intends to take;
2. The reasons for the intended agency action;
3. The specific regulations supporting such action;
4. An explanation of the individual's right to request a fair hearing;
5. An explanation of how to request a fair hearing;
6. The time limits on requesting a hearing;
7. An explanation of the right to examine evidence;
8. An explanation of the circumstances under which continued Medicaid coverage is continued if a hearing is requested;
9. An explanation of the requirement to repay Medicaid coverage received during the period pending the hearing, if the agency action is upheld;

10. A sentence in Spanish cautioning the client that the notice relates to a change in Medicaid coverage and if he or she does not understand the notice, he or she should contact the CBOSS; and

11. The name, address and phone number of the nearest legal services office where available.

(e) Where an agency decision results in an adverse action, there will be no termination of the AFDC-Medicaid related coverage until at least 10 days after the mailing date of the notice, except in situations described in (f) below.

(f) Timely notice may be dispensed with but adequate notice shall be sent not later than the effective date of action when:

1. The agency has factual information confirming the death of a beneficiary;

2. The agency receives a clear written statement signed by a beneficiary that he or she no longer wishes continued Medicaid coverage, or that gives information which requires termination, and the beneficiary has indicated, in writing, that he or she understands that this must be the consequence of supplying such information;

3. The beneficiary has been admitted or committed to an institution, that does not qualify for Federal financial participation under the State plan;

4. The beneficiary has been placed in a nursing facility, intermediate care facility or long-term hospital;

5. The claimant's whereabouts are unknown and agency mail has been returned by the post office indicating no known forwarding address. The Medicaid Card must, however, be made available to the beneficiary if his or her whereabouts become known during the medical coverage period, unless (f)5i below applies.

i. The claimant moves out-of-State, with apparent intent to remain permanently absent from New Jersey;

6. A beneficiary has been accepted for medical assistance in another state and that fact has been established by the CBOSS previously providing Medicaid coverage;

7. An AFDC child is removed from the home as a result of a judicial determination, or voluntarily placed in foster care by his or her legal guardian; or

8. The application for Medicaid coverage is being denied.

10:69-6.3 Responsibilities of the CBOSS in processing hearing requests

(a) Upon receipt of a timely request for a fair hearing, Medicaid coverage shall be continued until a written decision is rendered, unless:

1. A determination is made at the hearing by the ALJ that the sole issue is one of State or Federal law or policy, or change in State or Federal law, and not one of disputed facts; or

2. A change occurs which further affects beneficiary's eligibility while the first hearing decision is pending and the beneficiary fails to request an additional hearing after notice of this change within the time allowed.

(b) In the event of either (a)1 or 2 above, the beneficiary shall be promptly notified in writing that the proposed action will be implemented after the hearing while the decision is pending.

(c) Any incorrectly paid benefit resulting from continued Medicaid coverage is subject to recovery. In the event that agency action is sustained and a beneficiary has received incorrectly paid Medicaid benefit, solely due to continued eligibility, recovery shall be effected in accordance with procedures in N.J.A.C. 10:69-9.23.

(d) A beneficiary may waive his or her claim to Medicaid by submitting a written statement at the time the fair hearing is requested.

(e) To assure orderly and expeditious processing of complaints and hearing requests, each CBOSS shall designate a liaison between the county and State Division whose duties shall include, but not be limited to:

1. Informing the Bureau of Legal and Regulatory Liaison (BLRL) by telephone on the same day an oral or written request for a hearing is received, providing the following information:
   i. The case number and the applicant/beneficiary's name and address;
   ii. The date the request received;
   iii. The nature of contested action;
   iv. The date of action; and
   v. The reason for action;
2. Establishing a system to assure that every written request for a hearing received in the CBOSS office is stamped with the date of receipt and forwarded to BLRL within one work day of the date;
3. Reviewing incoming requests for possible corrective action prior to hearing;
4. Identifying and arranging for participation of staff individuals who are essential to a hearing, and assembling all records relevant to a hearing and arranging for an interpreter when the client is non-English speaking;
5. Contacting the applicant/beneficiary or his or her legal or authorized representative not less than two days prior to a hearing to confirm attendance and arranging for transportation by agency staff and vehicles or otherwise at agency expense when no other reasonable means of transportation is available;
6. Submitting special reports on hearing requests prior to the hearing date, when requested by OEP or BLRL;
7. Submitting reports on implementation of fair hearing decisions as soon as such action is taken when requested; and
8. Serving as the single individual in the CBOSS to be contacted regarding matters relating to hearings and the monitoring system.

(f) The CBOSS is responsible to inform the applicant/beneficiary who is requesting a hearing and elects to receive continued Medicaid that the ALJ may find him or her not entitled to all or a portion of the Medicaid coverage received during the pendency of the hearing and that, in such event, repayment may be required of the amount of benefits received from the effective date of the proposed adverse action to the date of the scheduled hearing.

1. The beneficiary shall also be advised that if he or she elects not to receive continued Medicaid coverage and the hearing decision is favorable to the client, Medicaid coverage shall be reinstated retroactive to when it was terminated.

10:69-6.4 Responsibilities of the Division of Medical Assistance and Health Services

(a) Each request for a fair hearing shall be registered by BLRL on the date the request is received.

(b) Requests initially received in BLRL shall be transmitted by telephone to the CBOSS on the date received.

(c) BLRL shall transmit each contested case to OAL within five work days of the receipt of the request.

(d) Written determination on entitlement to receive continuing Medicaid coverage shall be included in the OAL transmittal and sent to the applicant/beneficiary and the CBOSS.

10:69-6.5 Responsibilities of the Office of Administrative Law upon transmittal of a contested case from the DMAHS (45 CFR 205.10 and N.J.A.C. 1:1-1 et seq.)

(a) The Office of Administrative Law shall schedule the hearing and shall send any necessary notices to the parties.

(b) The hearing shall be conducted by an administrative law judge who shall issue an initial decision.

10:69-6.6 Administrative hearings and administrative reviews

(a) Requests on matters which constitute a contested case (as defined by N.J.A.C. 1:1-1 and consistent with case law) shall be handled in accordance with the Department of Human Services (DHS) rules on "Administrative Hearings and Administrative Reviews" at N.J.A.C. 10:6.

(b) Requests on matters which do not constitute a contested case (as defined by N.J.A.C. 1:1-1 and consistent with case law) shall be handled in accordance with the DHS rules on "Administrative Hearings and Administrative Reviews" at N.J.A.C. 10:6.

10:69-6.7 Complaints and adjustment procedures

(a) Prompt and courteous attention shall be given to all complaints, whether or not such complaints constitute requests for fair hearing and whether or not they are directed to the CBOSS or the Division of Medical Assistance and Health Services. All complaints received shall be acknowledged promptly and, if it is not apparent from the complaint that a fair hearing request has been made, the acknowledgment shall inform the beneficiary of his or her right to a fair hearing.

(b) Informal efforts to effect a resolution may be made through field contacts, office interviews with supervisory personnel, or consultation with Division staff as needed. In no event, however, are such informal efforts to be considered as prerequisite to a fair hearing, and in no event do they delay, interfere with or otherwise impede the processing of a fair hearing whenever a request for such is made. Agency emphasis shall be on helping the client to prepare and submit his or her request for a fair hearing.

(c) Any clear expression (oral or written) by a beneficiary (or person acting for him or her, such as his or her legal representative or relative) to the effect that the beneficiary wants the opportunity to present his or her case to a higher authority constitutes a request for a fair hearing.

(d) A request for a fair hearing may be either oral or in writing and addressed to the CBOSS or to the State Division. Oral requests for fair hearing shall be immediately reduced to a written record by the staff person to whom the request is made. No special form of statement or manner of expression is required so long as the request identifies the nature of the complaint and the relief sought. Requests made to the CBOSS shall be immediately transmitted to the BLRL, and in no event later than one work day after receipt of the request.

(e) Upon receipt of any request for a fair hearing, a determination shall be made by the Division on the appropriateness of an administrative hearing or administrative review (N.J.A.C. 10:6-1.2). If the matter is deemed contested, BLRL will send an acknowledgment of the request to the client. All contested cases shall be promptly forwarded to the OAL for a hearing before an ALJ.

10:69-6.8 Time limitations on entitlement to fair hearings

(a) An applicant or beneficiary has a right to request a fair hearing which relates to an agency action or lack of action within 20 days of such action or lack of action.

(b) If the request for a fair hearing relates to an agency action or lack of action that occurred more than 20 days prior to the date of the request, there shall be no entitlement to a hearing on such action or lack of action, unless extraordinary and extenuating circumstances exist as determined by the Division of Medical Assistance and Health Services. Extraordinary or extenuating circumstances are defined as

conditions beyond the applicant or beneficiary's control. This could include, but is not limited to, the beneficiary's receipt of notice after due date or personal illness or incapacity.

10:69-6.9 Eligibility for continued Medicaid coverage

(a) When a request is made for a fair hearing within 15 days from the date of mailing of a notice of termination, Medicaid coverage shall be continued until the scheduled date of the administrative hearing or the date of the administrative review unless the beneficiary waives such entitlement or requests postponement of the scheduled hearing or review date. In the event the beneficiary elects to receive continued benefits, they will be continued pending a final decision if the ALJ or the administrative review official determines that the issue is one of fact rather than law or policy. (45 CFR 205.10(a)(7))

(b) An adjournment of a hearing at the request of an beneficiary shall not prolong continuation of Medicaid coverage, unless the adjournment is due to delay caused by the State Division, OAL or the CBOSS; unavoidable causes, such as an illness on the part of the applicant/beneficiary; or the failure of the CBOSS to provide assistance for transportation when such assistance is required by regulations. Adjournment at the request of the CBOSS or by the ALJ shall not affect continued benefits.

(c) The CBOSS shall promptly inform the beneficiary in writing whether or not Medicaid coverage shall be continued unreduced pending a final decision.

10:69-6.10 Access to discovery of information in contested cases

The CBOSS shall provide the applicant/beneficiary and/or his or her authorized representative opportunity to review the entire case file or documents and records to be used in the administrative hearing. Such materials shall be made available at a reasonable time before the scheduled hearing date as well as during the hearing. (45 CFR 205.10(a)(13))

10:69-6.11 Representation at hearings

(a)Representation shall be pursuant to N.J.A.C. 1:10B-5.1.

(b) The CBOSS representative must have knowledge of the matter at issue and must be able to present the agency case, supplying the ALJ with that information needed to substantiate the agency action. If the CBOSS representative feels that he or she must be an advocate of the client and is unable to represent the agency, then another CBOSS staff person shall appear at the hearing to fulfill the above identified role.

(c) In hearings involving a determination by any component of the DMAHS, the matter at issue shall be presented by the appropriate staff representative(s) of the DMAHS.

10:69-6.12 Disposition of hearing request through withdrawal, abandonment or settlement

(a) Prior to transmittal to OAL, if a party desires that a hearing request be withdrawn, that party shall notify the CBOSS or DMAHS in writing of the withdrawal request. DMAHS shall in turn acknowledge, in writing, receipt of the withdrawal request. No CBOSS shall deny or dismiss a request for a fair hearing. The determinations on the validity of each hearing request shall be made by the Division of Medical Assistance and Health Services including any determination on the appropriateness of processing hearing requests pursuant to this subchapter.

(b) The filing of a request for a fair hearing shall not of itself preclude continued effort to accomplish corrective action, settlement, or any other agreement through informal procedures. Any withdrawal or abandonment or any settlement or agreement reached, subsequent to the transmittal of the case to the OAL, shall be processed according to N.J.A.C. 1:1, including any Rules of Special Applicability which may apply to disposition by settlement or withdrawal.

10:69-6.13 Adjournments

Any adjournment requested by an applicant or beneficiary and granted by the OAL may not operate to extend the deadlines for a final decision and final agency implementation of the final decision.

10:69-6.14 Hearings involving medical issues

(a) If the hearing involves medical issues, requiring a diagnosis or a report from an examining physician, or concerning a determination by the DMAHS Disability Review Unit, the ALJ may issue an order requiring a medical assessment by someone other than the person who made the original medical determination.

(b) The CBOSS shall pay for this medical assessment which shall be obtained at reasonable expense.

10:69-6.15 Decision by Director, Division of Medical Assistance and Health Services

(a) A final administrative hearing decision shall be rendered by the Director of the DMAHS. The applicant/beneficiary, his or her representative and the CBOSS shall be notified by mail of any decision or order.

1. Unless otherwise indicated, the decision shall be effective on the date of issuance.

(b) An official and complete record of each administrative hearing shall be maintained in the files of DMAHS and the CBOSS for at least one year after the date the final decision is rendered. During this one year period, the applicant/beneficiary or his or her legal representative may review, upon appointment, all or any part of the official and

complete record of his or her administrative hearing.

(c) A decision requiring action by the CBOSS may apply either prospectively with regard to future action by the CBOSS or retroactively to the date an incorrect action was taken. If the decision results from mutual agreement of the parties at the hearing and disposition by settlement and withdrawal, the terms of settlement will be binding upon the parties.

1. Administrative hearing decisions shall be retained by the DMAHS for a period of three years.

(d) The DMAHS shall take such steps as may be necessary to assure that the decision has been carried out. Corrective or remedial measures ordered by the hearing decision, unless otherwise directed in the decision, will be implemented by the CBOSS immediately upon receipt of the decision.

(e) Final administrative action on administrative hearing decisions, including any corrective action required by the decision, shall be implemented by the CBOSS within 90 days of the date of the request for a fair hearing.

END OF SUBCHAPTER 6

SUBCHAPTER 7. CASE RECORDS AND FILES

10:69-7.1 Purpose of case records

(a) The case record is the official file of forms, chronological narrative, correspondence and other documents pertinent to the application and eligibility of the client. It constitutes a complete record of the county board of social services' decisions and actions about eligibility for each case. Since it is the record of information on which decisions to grant, deny or continue Medicaid coverage in accordance with law and regulations are made, it is mandatory that a case record be established for every individual who applies for and/or receives Medicaid.

(b) The case record shall be kept absolutely confidential.

(c) The case record also serves:

1. To provide the information necessary for action in conformity with all relevant legal requirements in the county board of social services' relationship with the client;
2. To provide an adequate and accurate source of information for the Division of Medical Assistance and Health Services and Federal staff for statistical studies or other research purposes which will be statistical in nature and include no beneficiary's names; and
3. As an essential tool in supervision.

10:69-7.2 Contents of the case record

(a) The validity of all case action rests primarily on the significance of the data in the case record. The following items shall be part of the case record:

1. All completed forms necessary for the appropriate AFDC-related Medicaid programs;
2. Any pertinent narrative recording;
3. A log of each contact with client and summary of substance;
4. All medical reports, as appropriate; and
5. All case-related referrals, correspondence, memorandums and documents except those that are required by law or regulation to be maintained in some other files.

10:69-7.3 Documentation of verification of factors of eligibility

(a) It is essential that the CBOSS carefully document its verification of all eligibility requirements. It is extremely important that when reference is made to a document or source of verification, sufficient information be provided so that the document or source can be readily identified.

(b) The preferred method of documentation is inclusion in the case record of the original document, or photocopy of such document verifying a factor of eligibility.

1. If the eligibility worker has reviewed but not obtained a copy of a document, a description of the document and its location shall be included in the case record to facilitate review of the material, where necessary, by the Division of Medical Assistance and Health Services.

(c) There shall be instances where the limited space provided on the application for verification shall be insufficient to record all relevant facts. It shall then be necessary to provide whatever further information is needed through narrative recording in the case record. When this occurs, the eligibility worker shall indicate on the application that additional information is available in the case record.

10:69-7.4 Maintenance and custody of case records

(a) All financial eligibility record material relevant to each client or client group shall be maintained in a folder, jacket, or envelope bearing the appropriate registration number, separate and apart from material relevant to social services.

(b) All records shall be filed in a secure and fire-resistant room. A separate file shall be maintained for each program. The CBOSS director may further subclassify the case records in whatever manner is best suited to local administrative use and control, provided that all such classifications are cross-indexed so that it shall be possible to locate immediately the whole of any case record either by name or registration number.

10:69-7.5 Movement of case records

(a) No case record or official part of such record shall be removed from its designated filing cabinet without an identifying record of the person who has custody of it.

(b) Any case record or official part that has been removed from its designated filing cabinet shall be placed in some similar storage arrangement at the close of each business day.

(c) No case record or official part shall be removed from the offices of the county board of social services except at the specific authorization of the director, deputy director or other person specifically designated by the agency director to authorize such removal.

10:69-7.6 Transfer of case records

No case record or official part of such record shall be permanently removed from its designated filing cabinet unless and until it is transferred in its entirety to the custody of some other county board of social services or it comes under the provisions of N.J.A.C. 10:69-7.7.

10:69-7.7 Retention and destruction of case records

(a) Each county board of social services shall retain all material normally kept in the "case folder" for the time periods indicated in (b) below. At the expiration of such time period the CBOSS may, at its option, destroy records in accordance with (c) and (d) below, continuing to retain those portions indicated. In permanent available archives, the CBOSS shall retain information showing the date and manner of destruction of each "case folder" destroyed.

1. "Case folder" shall be construed to mean the entire set of financial eligibility records related to eligibility determinations for one person or household. Each such case folder may be reviewed as a single unit without reference to the fact that the person(s) involved may have received Medicaid or may be receiving Medicaid under another program.

(b) Retention periods are as follows:

1. In destroying records in this category, the agency shall provide for the permanent retention of information by which to assure itself in the future of the absence of a claim and the reason(s) therefor.

Case Folders	Retention Period
a. Cases denied or rejected without providing Medicaid coverage	Three years after the last official agency action or court action that influences the granting or recovery of
b. Cases in which all incorrectly provided Medicaid coverage has been repaid in full	Medicaid coverage or the receipt of the final recovery payment, whichever is later.
c. Cases in which no repayment was ever due	
d. Cases in which no further repayment is due (repaid fraud restitution, and other incorrectly paid benefits in all programs, repaid "suits and claims")	
e. Cases in which a specific agency decision has resulted in abandonment of a claim(s)	

2. The following concern records of cases in which reimbursement is owing:

i. In all instances of unresolved fraud or other incorrectly paid benefit matters,

unresolved "suits and claims" matters, all records in each case shall be retained until the matter(s) in question is resolved and the case falls into one of the groups listed below or in (b)1 above; then retain accordingly.

ii. In destroying records of cases in which reimbursement is owing, the agency shall retain enough information in permanent archives to provide clear identification of debtors, to document the amounts, and to allow thetaking of any legal or administrative action which may become necessary in the future by either the agency or by DMAHS.

iii. Records in cases in which reimbursement is owing shall be retained as follows:

Case Folders	**Retention Period**
AFDC-related Medicaid, New Jersey Care ... Special Medicaid Programs, Medically Needy, NJ KidCare, MAA, and Medicaid Only	
a. Beneficiary still living	Indefinite
b. Beneficiary deceased (see note below)	
(1) Probable recovery pending	Indefinite
(2) All known or probable recoveries completed or none possible	Three years after death or last official action, whichever is later

iv. In accordance with actuarial practice, persons not known to be deceased may be presumed dead at age 100 unless information to the contrary exists.

(c) Requests for destruction of case records shall be submitted on State Form ED-6, Request and Authorization for Records Disposal, which may be obtained from the Office of Eligibility Policy, Division of Medical Assistance and Health Services. Form ED-6 will be completed as follows:

1. Request Number and Date: Each county board of social services shall assign its own number to each request and the date upon which it was submitted;

2. Authorization Number and Date: For use of the Bureau of Archives and History;

3. From: Provide complete address of county board of social services;

i. Item: Number the items in sequence beginning with No. 1;

ii. Records Title and Description: Indicate the number of case records by categorical program and provide sufficient information to show where they are in the Record Retention Schedule;

iii. Inclusive Dates: Indicate the inclusive dates to which the material applies (for example, the earliest application was taken and the most recent year a case was closed);

iv. Volume: Volume is to be measured in cubic feet (one file drawer equals two cubic

feet). Measurements should be rounded to the nearest cubic foot; do not use a measurement less than one cubic foot;

v. Retention Period: Complete in accordance with subsection (b) of this section;

vi. Requested By: Signature of CBOSS director or authorized agent; and

vii. The appropriate State agency shall complete all other items;

4. All copies of the completed Form ED-6 shall be forwarded to the Office of Eligibility Policy for approval. The county board of social services shall not destroy any records until such approval has been received by the CBOSS in writing.

(d) When disposal is authorized, records shall be destroyed in fact and shall not be allowed to fall into unauthorized hands. Nonconfidential records may be sold for waste, providing that they will eventually be processed to destroy their identity. Confidential records shall be destroyed by burning, shredding or pulping, and a responsible official shall supervise such disposal or accompany the records, if they have to be transported, to see that they are in fact totally destroyed.

10:69-7.8 Agency controls for other operational procedures

(a) Each CBOSS director shall establish operational procedures and appropriate controls for the staff that will expedite the processing of applications and ensure maximum compliance with policy and regulations.

(b) Control records shall include identification of pending cases upon which action must be taken within 30 days of application, and shall indicate any case about which decision has not been made within the 30-day limitation.

10:69-7.9 Disclosure of records or information for formal proceedings

Pertinent information and records shall be released to the participants only, in the course of any fair hearing or in the course of any other formal proceeding provided for in Titles 30 and 44, New Jersey Statutes Annotated, and in the Federal Social Security Act.

10:69-7.10 Release of information for statistical purpose

Any statistical data or other information not including any names or personal information may be released.

END OF SUBCHAPTER 7

SUBCHAPTER 8. OTHER GOVERNMENTAL PROGRAMS

10:69-8.1 Retirement, Survivors and Disability Insurance

(a) Retirement, Survivors and Disability Insurance (RSDI) is a Federal program administered by the Social Security Administration (SSA) which provides protection to workers and their families against loss or stoppage of earnings resulting from retirement at age 62 or older, death and disability. The possibility of entitlement to Social Security benefits shall be explored with every applicant and beneficiary.

(b) Substantially all workers and self-employed persons, including military servicemen, are protected by Social Security coverage or are under another governmental retirement system (Civil Service or Railroad Retirement).

(c) Since Social Security benefits are an available resource, a beneficiary or applicant who has potential eligibility for such benefits, even at a "reduced" rate, shall apply for them.

10:69-8.2 Procedures for securing information from the Social Security Administration

(a) County boards of social services are required to use the Automated Benefit Information Exchange (ABIE)/Beneficiary Earnings and Data Exchange (BENDEX) and the State Data Exchange (SDX) as the primary source of verification of Social Security (RSDI) and Supplemental Security Income (SSI) benefit information.

(b) The State Verification and Exchange System (SVES) is to be used to obtain RSDI and SSI data for AFDC-related applicants and beneficiaries when ABIE/BENDEX and SDX information is not available.

(c) The SVES may be supplemented through use of Form SSA-1610-U2 (Social Security-Public Assistance Agency Request for Information) to resolve conflicts between other evidence and data shown in the ABIE/BENDEX, SDX and SVES files, for example, an identification problem.

10:69-8.3 Release of information by county board of social services to SSA

(a) When the Social Security Administration requests information to assist in determining an applicant's eligibility for any benefits, the county board of social services is authorized to release such information from its records.

(b) Medical information when requested shall be provided since this information will be used by professional medical personnel in determining disability status for disability benefits.

10:69-8.4 Entitlement of child born of unmarried parents

(a) A child born of unmarried parents may be entitled to RSDI benefits based on the earnings record of the birth mother or birth father subject to the conditions and proofs in this section.

(b) In New Jersey, a child born of unmarried parents has the requisite status for entitlement to RSDI benefits based upon the earnings record of the birth mother without meeting any special requirements beyond proof of the relationship.

(c) In New Jersey, a child born of unmarried parents may be entitled to RSDI benefits based upon the earnings record of the birth father under any of the following circumstances:

1. When the wage earner is the birth father and marries the mother;

2. When the wage earner has acknowledged in writing that the child is his. The acknowledgment need not be in any special form, but must identify the child in question and further identify such child as his own. Examples of an acceptable written statement include income tax return, a serviceman's application for allotment, a will, an application for insurance, or a letter:

i. The written statement should be signed by the wage earner, but an unsigned statement may have value if there is evidence that it was prepared by the wage earner;

3. When the wage earner has been determined to be the father under the provisions of N.J.S.A. 9:16-1 et seq. or 9:17-1 et seq., or he has been ordered to contribute to the support of the child on the basis of a determination that such child is his, at a point in time which is:

i. Not less than one year before the time he became entitled to retirement benefits or attained age 65, whichever is earlier;

ii. Before the beginning of his most recent period of disability on which his claim for disability benefits is based; or

iii. Before his death;

4. The adjudication of paternity or order of support must identify the child in question and further identify such child as the son or daughter of the wage earner. The amount directed to be paid for the support of the child, or whether support payments are actually made, is immaterial; or

5. When there is satisfactory evidence of paternity and the birth father was living with or contributing to the support of the child as of the time:

i. The birth father became entitled to retirement benefits or attained age 65, whichever is earlier;

ii. The birth father's most recent period of disability began; or

iii. The birth father died.

(d) Under the conditions of this section, "satisfactory evidence of paternity" is the existence of a written acknowledgment, an adjudication of paternity or an order of support regardless of the time the action occurred.

10:69-8.5 Division of Employment Services

(a) The Division of Employment Services within the State Department of Labor is responsible for the administration of the Unemployment Insurance and Temporary Disability Benefits.

(b) The Division of Employment Services maintains local offices and provides itinerant services at necessary points, which vary from time to time with economic conditions, on specified days or during specified seasons of the year. The county board of social services may obtain copies of a published list of the local and itinerant offices from the Division of Employment Services, John Fitch Plaza, Trenton, New Jersey 08625.

(c) It is essential that the county board of social services staffs familiarize themselves with the general rules of eligibility for receipt of unemployment insurance and temporary disability benefits, payment provisions and duration of weekly payments for persons who have been engaged in "covered" employment.

(d) The following concern the verification of the status of a claim for unemployment insurance:

1. Claims for unemployment insurance benefits are filed at the appropriate local office of the State Employment Service.
2. It should be possible for the agency to secure from the client all the necessary information about his or her eligibility for and the receipt of unemployment insurance benefits.
3. When a client cannot provide the information and fails in his or her efforts to secure it himself or herself, or there is reason to believe that the client is furnishing inaccurate or incomplete information, the agency shall obtain information on-line via access to the New Jersey Treasury computer system.

(e) The following concern the verification of the status of a claim for temporary disability benefits:

1. Unlike claimants for unemployment insurance benefits, persons who have filed for temporary disability are not provided with proof of application for benefits. However, they receive an Entitlement Statement from Disability Insurance Service.
2. It is the responsibility of the client to notify the agency of the status of his or her claim for benefits. The agency shall inquire from him or her whether he or she is covered under a private plan or State plan.
3. If the client still has not received payment, or notice of ineligibility for benefits for a claim made under the private plan, a direct inquiry in writing shall be sent to the

employer. If filed under the State plan, inquiry shall be made through the New Jersey Treasury computer system. In such instances, Medicaid coverage shall be continued until receipt of a payment or indefinitely if payment does not cause ineligibility for AFDC-related Medicaid.

10:69-8.6 Functions of the Department of Veterans Affairs

(a) The Department of Veterans Affairs operates the Federal program of benefit payments and health and welfare services to veterans and to certain of their dependents or survivors. To be eligible for these benefits and services, the veteran, serving in either war or peacetime service, shall have been released with other than a dishonorable discharge.

(b) Exploration of veterans benefits is a condition of eligibility for AFDC- related Medicaid provisions as follows:

1. Veterans benefits are a resource for a number of AFDC-related Medicaid beneficiaries, and shall be carefully explored in the process of determining need.

2. In the case of a person who is a veteran (or a dependent or survivor of a veteran) and presumptively eligible for any form of veterans benefits, it shall be required as a condition of eligibility for AFDC-related Medicaid that application for such benefits be made and fully processed.

i. The exception to this requirement are certain persons who had been receiving Veterans Administration (VA) pensions prior to December 1978 and elected to continue receiving "lower" pension amounts in order to retain AFDC-related Medicaid eligibility. Those individuals shall not, as a condition of eligibility for AFDC-related Medicaid, be required to apply for "improved" or higher pension amounts to which they may be entitled.

(c) Information concerning eligibility for benefits and services may be obtained from the following sources:

1. The details of all benefits and services are outlined in fact sheets issued by the Department of Veteran Affairs.

2. The New Jersey Bureau of Veterans Services, Department of Military and Veterans Affairs, maintains service offices to which persons seeking information or wishing to file for veterans benefits or services may be referred. The Department of Military and Veterans Affairs can be reached by calling 1-800-624-0508. That agency can provide the addresses of the local Veterans Service Office.

10:69-8.7 Availability of Work First New Jersey

It is the responsibility of the county board of social services staff to inform clients and members of their immediate families of the availability of general assistance, if appropriate.

END OF SUBCHAPTER 8

SUBCHAPTER 9. OTHER AGENCY RESPONSIBILITIES

10:69-9.1 Adherence to law and regulations

There must be strict adherence to Federal and State law and regulations. Requirements other than those established pursuant to Federal and State law and regulations shall not be imposed as a condition of receiving AFDC-related Medicaid.

10:69-9.2 Issuance of manual

(a) Rules concerning assignment and responsibility are as follows:

1. The director of the county board of social services shall assign copies of this chapter as an eligibility manual to administrative staff and all other income maintenance staff members working with applicants and beneficiaries and to social services staff as appropriate and shall ensure that each staff member is thoroughly familiar with its contents and applies the required policy and procedures consistently.

2. The Division Medical Assistance and Health Services (DMAHS) shall issue updates to this chapter with revisions duly promulgated in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., as well as informational materials, as necessary. It is the responsibility of each holder of the manual to maintain its accuracy by inserting new material and removing obsolete pages promptly.

3. One administrative copy of obsolete material related to this manual shall be kept by the county board of social services.

(b) This eligibility manual is a public document. It is extremely important that all copies in use be absolutely accurate and up-to-date. It is available as follows:

1. Copies are available in the State office of the Division of Medical Assistance and Health Services and in each county board of social services office for examination or review during regular office hours on regular work days.

2. Specific policy material necessary for an applicant or beneficiary or his or her representative to determine whether a hearing shall be requested or to prepare for a hearing shall be provided to such persons without charge.

3. Welfare, social service and other nonprofit organizations shall be furnished with a copy of this manual at no cost by an official written request to:

Division of Medical Assistance and Health Services
Bureau of Policy and Intergovernmental Relations
Division of Medical Assistance and Health Services
Mail Code #26
PO Box 712
Trenton, NJ 08625-0712
Fax: 1-609-588-7672

4. A current up-to-date copy of the manual or any part of it is available from the Division of Medical Assistance and Health Services at the cost of printing and mailing to anyone who requests it in writing at the above- mentioned address in (b)3 above.

5. All State policy directives and supplementary information shall routinely be sent to those who have been supplied with the eligibility manual and have requested to be added to the mail list. The mailing list shall be maintained by the Division.

10:69-9.3 CBOSS reporting requirements

The CBOSS shall provide all reports as requested by the Division of Medical Assistance and Health Services (DMAHS).

10:69-9.4 Issuance of Medicaid cards (validation of eligibility)

(a) Each month, the county board of social services shall issue to each person or family currently eligible for AFDC-related Medicaid a validation of such eligibility. The validation shall be in a form approved by the Division of Medical Assistance and Health Services. The validation shall, at a minimum, contain the agency's name and address, the indication that this is a Medicaid validation card, and the name and Medicaid number of each eligible family member.

(b) Upon notification from a client that his or her Medicaid card has been lost or stolen, the CBOSS shall immediately issue a replacement card.

10:69-9.5 Separation of income maintenance and social services

(a) Income maintenance includes responsibility for applications, determining eligibility and continuing eligibility and verification of eligibility factors.

(b) Social services are those activities directed toward informing applicants and beneficiaries of available services, and assisting individuals and families by providing direct service, purchasing service or by referral to a community agency.

1. The client shall be as fully informed as possible at each contact by staff of each unit of the programs and services for which he or she may be eligible.

2. Some situations that would call for social services include:

i. A change in circumstances possibly affecting need for services;

ii. Follow-ups resulting from recommendations of the Disability Review Section;

iii. Exploring potential for services from other agencies;

iv. Protective services for children;

v. Early periodic, screening, diagnosis and treatment;

vi. Family planning; and

vii. Any other apparent need for services.

3. Interrelated activities which specifically involve TANF eligibility or other services include, but are not limited to:

i. Sharing information concerning IV-D child support and AFDC-related Medicaid;

ii. Sharing information concerning need of emergency assistance by a family; and

iii. Determinations of gross income and family size at time of case closing for post-AFDC-related Medicaid benefit purposes.

10:69-9.6 Payment of funeral and burial expenses; all segments

Funeral and burial expenses may be provided for AFDC-related Medicaid beneficiaries (all segments) as regulated in N.J.A.C. 10:90-8.

10:69-9.7 Reporting of child abuse and neglect

County boards of social services are required to report known or suspected instances of child abuse and neglect of a child receiving AFDC-related Medicaid to the Division of Youth and Family Services. Instances of abuse and neglect involve situations where a child experiences physical or mental injury, sexual abuse or exploitation or negligent treatment or maltreatment under circumstances that indicate that the child's health or welfare is threatened.

10:69-9.8 Confidentiality of information

(a) No member, officer, or employee of the county board of social services shall produce or disclose any confidential information to any person except as authorized below.

1. Information considered confidential includes, but is not limited to, the following:

i. Names and addresses, including lists;

ii. Information contained in the application, reports of investigation, report of medical examinations, correspondence and other records concerning the condition or circumstances of any person from whom or about whom information is obtained, and including all such information whether or not it is recorded; and

iii. Records of evaluation of such information.

2. The county board of social services may disclose information concerning an applicant or eligible person to persons and agencies directly related to the administration of the AFDC-related Medicaid program. Persons and agencies directly related to program administration are those who are properly authorized to be involved in the following:

i. The establishment of eligibility;

ii. The determination of the amount and scope of medical coverage;

iii. The provision of services for beneficiaries; and

iv. The conduct or assisting in the conduct of an investigation, prosecution, or civil or criminal proceeding related to the AFDC-related Medicaid program.

3. The county board of social services may release information whenever the applicant or eligible person waives confidentiality, but only to the extent authorized by the waiver.

4. If a court issues a subpoena for a case record or any other confidential information or for any agency representative to testify concerning an applicant or eligible person,

the county board of social services shall make a statement substantially as follows:

i. "Under provisions of the Social Security Act, information concerning applicants and beneficiaries of medical assistance must be restricted to persons directly connected to the administration of such assistance. Officials of the Federal government have advised that this includes a requirement of nondisclosure of such information in response to a subpoena. If a disclosure is made of this information, either by personal testimony or by the protection of records, this is considered nonconformance with Federal requirements and may subject the State to loss of Federal financial participation in the medical assistance program."

5. In no instance is it intended that any officer or employee of the county board of social services place him or herself in contempt of court through the refusal to follow orders of the court. In any instance of a subpoena for case record information or for agency testimony, a complete report of the disposition of the court's request shall be entered into the case record.

6. Pertinent information and records may be released in conjunction with any administrative hearing conducted by the Office of Administrative Law regarding action or inaction of the county board of social services affecting an applicant's or eligible person's eligibility or entitlement under the Medicaid program.

i. The CBOSS may release information whenever the applicant or eligible person waives confidentiality, but only to the extent authorized by the waiver.

ii. If a court issues a subpoena for a case record or any other confidential information or for any agency representative to testify concerning an applicant or eligible person, the CBOSS shall make a statement substantially as follows:

(1) "Under provisions of the Social Security Act, information concerning applicants and beneficiaries of medical assistance must be restricted to persons directly connected to the administration of such assistance. Officials of the Federal government have advised that this includes a requirement of nondisclosure of such information in response to a subpoena. If a disclosure is made of this information, either by personal testimony or by the protection of records, this is considered nonconformance with Federal requirements and may subject the State to loss of Federal financial participation in the medical assistance program."

iii. In no instance is it intended that any officer or employee of the CBOSS place himself or herself in contempt of court through the refusal to follow orders of the court. In any instance of a subpoena for case record information or for agency testimony, a complete report of the disposition of the court's request shall be entered into the case record.

iv. Pertinent information and records may be released in conjunction with any administrative hearing conducted by the Office of Administrative Law regarding action or inaction of the CBOSS affecting an applicant's or eligible person's eligibility or entitlement under the NJ KidCare program.

10:69-9.9 Disclosure of records or information for formal proceedings

Pertinent information and records shall be released to the participants only, in the course of any fair hearing or in the course of any other formal proceeding provided for in Titles 30 and 44, New Jersey Statutes Annotated, and in the Federal Social Security Act.

10:69-9.10 Release of information for statistical purpose

Any statistical data or other information not including any names or personal information may be released.

10:69-9.11 Material sent to applicants or beneficiaries of AFDC-related Medicaid program

(a) All materials distributed to program applicants or eligible persons shall:

1. Directly relate to the administration of the AFDC-related Medicaid program;
2. Have no political implications;
3. Contain names only of individuals directly connected with the administration of the AFDC-related Medicaid program; and
4. Identify those individuals only in their capacity with the State or the CBOSS.

(b) The CBOSS shall not distribute materials such as "holiday" greetings, general public announcements, voting information, or alien registration notices.

(c) The CBOSS may distribute materials directly related to the health and welfare of program applicants and eligible persons, such as announcements of free medical examinations, availability of surplus food, and consumer protection information.

10:69-9.12 Nondiscrimination

(a) Title VI of the Federal Civil Rights Act of 1964 (P.L. 88-352), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 70b), and the Americans with Disabilities Act, P.L. 101-336, codified as 42 U.S.C. § § 12101 et seq., prohibit discrimination on the ground of race, color, national origin, or handicap in the administration of any program for which Federal funds are received. Strict compliance with the provisions of these acts and any regulations based thereon is required as a condition to receive Federal funds for the assistance programs administered by the county boards of social services.

1. The CBOSS shall inform all staff members of their obligations in regard to the Civil Rights Act of 1964, and section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act.
2. All persons seeking medical assistance shall be informed of Title VI of the Civil Rights Act of 1964 and section 504 of the Rehabilitation Act of 1973.
3. All persons seeking or receiving medical assistance shall be afforded an opportunity to file a complaint alleging discrimination on the ground of race, color, national origin, or handicap. Such complaints may be filed directly with the Regional Manager, U.S. Department of Health and Human Services, Office of Civil Rights,

Federal Plaza, New York, New York 10007, or with the Director, Division of Medical Assistance and Health Services, PO Box 712, Trenton, New Jersey 08625-0712.

4. In any instance in which a complaint of alleged discrimination is filed with a State or county agency, the complaint shall be forwarded immediately to the Director, Division of Medical Assistance and Health Services. The Director, upon receipt of any such complaint, shall take any such action he or she deems appropriate to the situation. This action may include, but is not limited to, the securing of reports from whatever sources have knowledge pertinent to the situation and referral to the Division of Civil Rights of the New Jersey Department of Law and Public Safety, for investigation, evaluation, and recommendation by that agency.

5. The CBOSS shall afford full cooperation in the investigation of complaints of discrimination as may be requested by the Federal Department of Health and Human Services, the State Division of Medical Assistance and Health Services, or the State Division of Civil Rights.

10:69-9.13 Extent of prohibited discriminatory practices

(a) The discriminatory practices prohibited under N.J.A.C. 10:69-9.12 extend to all county board of social services offices.

(b) Prohibited discriminatory practices extend to services purchased or otherwise obtained by the county board of social services from other agencies, organizations, and institutions for beneficiaries of the program, and to the treatment of clients in facilities in which such services are provided.

1. In case of medical emergencies, the county board of social services is authorized to utilize the services of any medical institution for the duration of the emergency, even though such institution refuses or fails to comply with the requirements prohibiting discriminatory actions. Both the following conditions must exist:

i. The emergency must be such that the immediate provision of services or other benefits to an individual is necessary to prevent his or her death or serious impairment of his or her health; and

ii. Such services or other benefits are not immediately available from any other medical institution.

10:69-9.14 Procedures regarding payments to vendor

(a) The county board of social services shall establish procedures to ensure that all vendors to whom payment is being made, other than medical services, including, but not limited to, transportation, will receive on an annual basis a copy of Form WD-1A, A Statement Concerning Obligations of Vendors.

1. The county board of social services shall maintain a record of those vendors who have received this form, with the date of mailing.

(b) Rules concerning the assurance of compliance by vendors are:

1. All official invoice forms of the county board of social services shall contain the following statement directly above the vendor's signature:

i. "Services are provided to all beneficiaries without regard to race, color, national origin, sex, marital, parental or birth status, or disability."

2. The county board of social services, in the course of regular work activities, shall seek information concerning compliance and shall instruct staff to be alert to discover instances of discrimination on the part of physicians, dentists, optometrists, pharmacists, opticians, podiatrists, and other individual vendors in New Jersey, who receive payment for services directly from the county board of social services on behalf of AFDC-related Medicaid applicants or beneficiaries.

3. Any evidence of discrimination by the vendors described in (b)2 above that comes to the attention of the county board of social services shall be reported immediately to the Director, Division of Medical Assistance and Health Services.

10:69-9.15 Eligibility fraud by applicants and beneficiaries

(a) To protect the county board of social services and the public, it is essential to exercise appropriate controls against the commission of fraud relating to program eligibility.

(b) A person is presumed innocent until convicted. Therefore, except as provided in (c) below, Medicaid coverage shall be continued to an eligible person, even though there is reason to suspect that fraud has been committed, while the facts are under review by the agency or the law enforcement authority.

(c) Resolution of the question of possible fraud requires the cooperation of the beneficiary to protect his or her own interest; therefore, a beneficiary's failure or refusal to cooperate in the investigation would be grounds for suspending Medicaid coverage pending resolution of the issue. If during the investigation of an application for Medicaid, substantial evidence of fraud appears, disposition of the application shall be deferred pending resolution of the issue.

(d) Statutory authority regarding the identification and prosecution of Medicaid fraud may be found in New Jersey Statutes Annotated, and includes, but is not necessarily limited to, the following:

1. N.J.S.A. 2C:20-4 Theft by Deception;
2. N.J.S.A. 2C:21-1a Forgery;
3. N.J.S.A. 2C:21-3b Offering a False Instrument for Filing;
4. N.J.S.A. 2C:28-2 False Swearing;
5. N.J.S.A. 2C:28-3 Unsworn Falsification to Authorities;
6. N.J.S.A. 2C:28-7 Tampering with Public Records or Information; and
7. N.J.S.A. 30:4D-17 Penalty for Medicaid fraud

10:69-9.16 Criteria for identifying cases of possible fraud

(a) Fraud is defined as obtaining or attempting to obtain Medicaid coverage to which an individual is not entitled by means of willful misrepresentation or by intentional concealment of a relevant fact. There are three basic elements that must be established:

1. The misrepresentation or concealment must have been deliberate and done knowingly. Fraud does not exist if the misrepresentation or concealment is the result of an unintentional act, a misunderstanding or mental incompetency. Distinction must also be made between intent to defraud by the individual and omission, neglect or error by the agency's representatives in securing and recording information;

2. The misrepresentation or concealment must have been undertaken for the express purpose of receiving or obtaining benefits or attempting to receive or obtain benefits; and

3. If the county boards of social services had known the misrepresentation or concealment, or attempt to misrepresent or conceal a relevant fact, Medicaid coverage would not have been granted.

(b) The evidence to establish the points in (a) above must be factual and capable of being demonstrated in a court of law through the testimony of witnesses or by documentary evidence. Since fraud is subject to criminal action, it must be proved beyond a reasonable doubt.

10:69-9.17 County board of social services responsibility; administrative plan

(a) The role of the county board of social service is limited to responsibility for determining whether there is a basis in fact for believing that fraud may have been committed so that referral to the county prosecutor, other proper law enforcement official, or Division of Medical Assistance and Health Services for legal action is justified. The action taken by the law enforcement official following referral determines what further legal action shall be pursued. Whether fraud has actually occurred is a question for the courts.

1. The CBOSS director may utilize the power of subpoena given him or her by N.J.S.A. 44:7-20 to secure testimony and records pertinent to the investigation and needed to determine true facts.

(b) Each CBOSS shall develop an operational method to carry out its responsibility that is best suited to its administrative structure and to local conditions and resources. There must be clear allocation of duties and functions in the total process of including investigation, reporting, evaluation, and the decision to refer. In respect to the function of investigation, the county board of social services may select one or a combination of the following plans:

1. Cooperative arrangements with other county agencies:

i. The county board of social services may arrange for special investigation of cases

of suspected fraud by another appropriate agency or official such as office of the county adjuster, the probation department or the office of the county prosecutor, without cost to the CBOSS.

2. The county board of social services may appoint a "special investigator(s)" whose duty shall be to give special attention to case situations involving suspicion of fraud (and other related situations requiring special investigating skills), to prepare the necessary reports, and to function in a liaison capacity for the director and county board of social services to the law enforcement authorities. Such special investigator(s) shall have no law enforcement authority, and shall not engage in activity which is properly the responsibility of the eligibility worker.

3. The CBOSS may elect to have staff carry the responsibility for the necessary special investigation in instances of suspected fraud, relying upon consultation with CBOSS counsel for the technical aspects of establishing adequate evidence on which to base a decision.

4. Whatever administrative plan is adopted, there will be instances where discussion should be arranged with county board of social services counsel and/or the county prosecutor's office as to the nature and conduct of the investigation.

(c) The CBOSS shall file with the Division of Medical Assistance and Health Services a detailed description of the administrative plan, and shall advise the division of any subsequent proposed change in the plan before it becomes effective.

10:69-9.18 Referral by the CBOSS in cases of suspected fraud

When the investigation of any case of suspected fraud is completed, the director of the CBOSS, in consultation with counsel, shall be responsible for determining whether the matter should be referred to the county prosecutor, other proper law enforcement official and/or the Division of Mental Health and Health Services (DMAHS).

10:69-9.19 Reports on cases involving fraudulent receipt of Medicaid coverage

(a) In cases where the CBOSS has completed an investigation based upon a belief that fraud has been committed, a report shall be routed through the CBOSS director to the Division of Medical Assistance and Health Services. The report shall be completed when the CBOSS determines that no fraud exists, when the case is disposed of through administrative action, or when the case is forwarded to the county prosecutor.

(b) Upon disposition of the case by law enforcement officials (county prosecutor or municipal court), a subsequent report shall be completed and routed through the CBOSS director to the Division of Medical Assistance and Health Assistance.

10:69-9.20 Recovery of incorrectly paid Medicaid benefits

(a) In every fraud case, in addition to any criminal prosecution, recovery of the amount of assistance provided for medical care or supplies shall be sought. If the beneficiary is

involved in a Medicaid managed care plan, the higher of the payments made by the managed care plan or the amount expended by the Medicaid program for capitation costs shall be recovered. Recoveries of incorrect assistance by the CBOSSs shall be governed by N.J.A.C. 10:49- 14.4(b). Recovery of civil penalties shall be pursued by DMAHS in accordance with N.J.S.A. 30:4D-17(c). The threat of prosecution should not be used as a means of effecting recovery; nor should the fact of a recovery affect the CBOSS decision concerning proper referral to the prosecutor. However, any recovery, or plan for recovery, should be reported to the prosecutor whenever such a referral has been made.

(b) The provision of (a) above is not intended to limit the responsibility and obligation of the CBOSS to seek recovery, through voluntary agreement or civil action, of funds improperly received by a client under circumstances other than fraud.

10:69-9.21 Reporting criminal offenses to law enforcement authorities

(a) Investigation of new applications or investigations for redetermination of eligibility may indicate to the CBOSS that a crime may have been committed. Allegations of the suspected commission of a crime may also be made known to the CBOSS through various other sources, including, but not limited to, phone calls, written communications, or verbal communications from individuals. In matters of reporting of criminal offenses, the CBOSS shall, at all times, maintain full compliance with the provisions of N.J.A.C. 10:69-7.31, dealing with basic principles for safeguarding of information.

(b) The nature of offenses which must be reported to local authorities are:

1. Arson, manslaughter, murder or any crimes which constitute crimes of the third, second and first degrees, such as atrocious assault and battery, carnal abuse, incest or rape. (Refer to legal counsel for additional information identifying crimes of the third, second and first degrees.); and

2. In order to afford protection to children, certain other crimes and abuses as required by Federal, State or local statute or regulations must also be reported to the proper authorities.

(c) Knowledge of the actual commission of a Federal felony must be reported to Federal authorities unless law prohibits the disclosure of such information. (Refer to legal counsel for identification of Federal felonies.)

(d) When the CBOSS becomes aware of facts that would indicate that one of the crimes in (b) or (c) above has been or may have been committed or receives a direct allegation in any form, written, verbal or anonymous, that such a crime has been committed, it shall proceed as follows:

1. The CBOSS director shall personally, and in collaboration with counsel, review whatever facts and circumstances are immediately available in order to determine

whether there is suspicion that a crime was committed.

2. If the CBOSS director is satisfied that there is evidence to support an investigation as to whether a crime has been committed, he or she shall, after consultation with counsel, report the matter to the county prosecutor, or to a local police department or to the State Police if so directed by the office of the prosecutor. If such matter involves suspected child abuse or neglect, it shall also be reported to the social service unit which shall contact the Division of Youth and Family Services. (See N.J.A.C. 10:69-3.11).

3. When a decision has been made to report the alleged or suspected commission of the crime, such report shall be made in written form to the appropriate law enforcement agency.

4. The CBOSS shall cooperate fully with any subsequent investigation initiated by the law enforcement agency within the limits of this chapter. A CBOSS staff member may sign a written complaint only upon a written request from the law enforcement agency, provided his or her information of the facts to be stated in such complaint is based upon his or her own personal knowledge and belief.

10:69-9.22 Rights of individual under investigation

(a) The CBOSS shall insure that an individual under investigation shall have the following rights:

1. The agency shall insure that information obtained from or concerning a person under investigation shall be restricted in accordance with N.J.A.C. 10:69-9.8. The agency shall take special precautions in obtaining information from a third party so that no accusations relevant to the alleged fraud are disclosed, including the reason for the investigation or the nature of the allegation, without the written consent of the individual under investigation.

2. The agency shall insure that investigative methods do not infringe on the civil liberties of the individual or interfere with due process of law. The agency shall be prohibited from obtaining forced entry, conducting residence searches without consent of the client, making home visits during normal sleeping hours (generally 10:00 P.M. to 7:00 A.M.) or requiring that an individual be subjected to a lie detector test.

3. The individual shall be advised of the opportunity, where available, to obtain legal counsel through Legal Services, Legal Aid Society, lawyer referral service of the Office of the Public Defender.

10:69-9.23 Basis for recovery of incorrectly paid benefits for purposes other than for fraud, or third party liability

(a) Incorrectly paid benefits means Medicaid coverage received by or for an eligible unit for which they were otherwise not entitled. The overpayment was caused by reasons other than fraud or third party liability.

(b) Incorrectly paid benefits may occur through administrative error; failure of a client to

inform the county board of social services or designee pursuant to Federal regulation of a change in income or circumstances; or when the client has received continued Medicaid coverage but has been found ineligible to receive such Medicaid coverage or part of such coverage by the fair hearing decision.

(c) The CBOSS or designee pursuant to Federal regulation shall seek recovery of all overpayments regardless of fault including AFDC-related Medicaid payments caused by administrative action or inaction. The CBOSS or designee pursuant to Federal regulation shall recover such incorrectly paid benefits in accordance with procedures set forth in this chapter.

(d) Medicaid incorrectly paid benefits to an eligible unit, all members of which are no longer receiving AFDC-related Medicaid program, shall be recovered by the CBOSS through a court of appropriate jurisdiction if the family does not voluntarily repay the overpayment.

(e) In locating former beneficiaries who have outstanding incorrectly paid benefits, the CBOSS shall use appropriate data sources such as unemployment insurance files, the Division of Taxation, the Department of Motor Vehicles, Bendex, and other data sources relating to current or former beneficiaries.

(f) For incorrectly paid benefits occurring prior to October 1, 1981, the CBOSS shall recover only if the overpayment resulted from willful withholding of information by the beneficiary.

(g) The CBOSS may waive recovery of AFDC-related Medicaid incorrectly paid benefits if the eligible unit is no longer receiving AFDC-related Medicaid and the amount overpaid is less than $35.00. When the amount of the incorrectly paid benefit to an eligible unit no longer receiving AFDC-related Medicaid is $35.00 or more, the CBOSS may waive the recovery of the incorrectly paid benefit, if after a reasonable effort to recover the incorrectly paid benefits, the CBOSS determines it is no longer cost effective to continue recovery efforts. Recovery of overpayments due to fraud may not be waived regardless of the amount of incorrectly paid benefit.

1. Reasonable efforts to recover an incorrectly paid benefits include, at a minimum, written notification of the amount of and reason for the incorrectly paid benefit and that repayment is required.
2. All circumstances concerning a waiver of recovery must be fully documented in the case record.

(h) The CBOSS shall not initiate or continue recovery of any outstanding incorrectly paid benefits of Medicaid coverage that occurred in another state.

END OF SUBCHAPTER 9

SUBCHAPTER 10. INCOME

10:69-10.1 Income; financial eligibility standards

(a) As a condition of eligibility for the AFDC-related Medicaid program, applicants must comply with the income standards set forth in this subchapter.

(b) It is the purpose of this subchapter to establish methods for evaluating income eligibility for families and children.

10:69-10.2 Standard of need (Effective 7/1/92)

(a) New Jersey has established the following monthly Standard of Need:

Standard of Need

Number in Family	Monthly Standard
1	$ 410
2	$ 819
3	$ 985
4	$1,127
5	$1,260
6	$1,386
7	$1,505
8	$1,617
more than 8	add $112 each person

10:69-10.3 Total gross income limits

(a) AFDC-related Medicaid program eligibility shall not exist for any month if the total income of the eligible unit exceeds the amount indicated in this subsection for the appropriate eligible unit size. For this purpose, total income shall include all income of the eligible unit (without benefit of the disregards described in this subchapter including the income of stepparents (exception: see (a)4 below concerning non-needy stepparents who marry an AFDC- C related Medicaid program parent on or after October 1, 1992)) and alien sponsors income determined available to the eligible unit as described in N.J.A.C. 10:69-10.43. Total income includes the earned income of the AFDC children except for earnings disregarded by provisions of N.J.A.C. 10:69- 10.15. Child support payments, except for the first $50.00 monthly current child support received on behalf of the eligible unit, whether received directly by the household or collected through the Child Support and Paternity (CSP) process, shall be counted in

the determination of total income. See N.J.A.C. 10:69-10.35 for companion cases.

1. The TANF grant shall not be considered as income for this purpose.

2. Funds exempted under N.J.A.C. 10:69-10.15 or 10.22(b)4 through 8, 10.22(c)6 through 8, 11.22(b)6 through 8 and moneys disregarded under N.J.A.C. 10:69-4.6 shall not be considered income for this purpose.

3. The following table represents 185 percent of the State's Standard of Need set forth in N.J.A.C. 10:69-10.2.

Maximum Income Levels

AFDC-C, -F and -N	Number in Eligible Unit
$ 758	1
1,515	2
1,822	3
2,085	4
2,331	5
2,564	6
2,784	7
2,991	8
Add $207	more each additional Person than 8

(b) AFDC-related Medicaid program income eligibility standards are set forth below. The income standards are established for the eligible family unit according to the number of persons in the eligible unit.

Income Standards

AFDC-C, -F and -N	Number in Eligible Unit
$185	1
369	2
443	3
507	4
567	5
624	6
677	7
728	8
Add $50.00	more each additional person than 8

(c) Countable income sources (both earned and unearned, after application of all appropriate disregards) of an eligible family shall be subtracted from the income standard for the eligible family size set forth in (b) above to determine if the family is eligible for AFDC-related Medicaid.

1. The income standards under (b) above represent a ratable reduction of 45 percent of the State's Standard of Need set forth at N.J.A.C. 10:69-10.2 for the eligible family unit size.

10:69-10.4 Eligible unit; all related Medicaid programs

(a) The eligible unit shall be comprised of those family members who apply for and are eligible to receive AFDC-related Medicaid program. It shall include one or more eligible children unless such child is a related Medicaid program beneficiary of SSI benefits.

1. The eligible unit for AFDC-C or -F related Medicaid program shall include any blood-related or adoptive brothers and/or sisters living in the same household and who are otherwise eligible for AFDC-C or -F related Medicaid program. This requirement does not apply to stepbrothers and stepsisters, in circumstances in which AFDC-related Medicaid program is sought for -N related Medicaid program children only.

2. A stepparent of the children for whom AFDC-related Medicaid program is sought may be included in the eligible unit if the provisions of N.J.A.C. 10:69-10.33 apply. If the non-needy stepparent marries the AFDC-C related Medicaid program beneficiary parent on or after October 1, 1992 and the provisions of N.J.A.C. 10:69-3.4 apply, the stepparent and his or her natural or adoptive children, as well as the natural or adoptive AFDC-C related Medicaid program beneficiary parent, shall be excluded from the eligible unit.

(b) When a related Medicaid program beneficiary of SSI payments is a family member, he or she shall not be included in the eligible unit.

1. When all eligibility factors are present in a family of two or more people, the individuals not receiving SSI benefits shall comprise the eligible unit. This applies to a parent as well as to a child.

(c) An adult who incurs a penalty of ineligibility shall not be included in the eligible unit (see N.J.A.C. 10:69-10.28).

(d) The eligible unit shall include the parent(s) and/or needy parent- person(s) with whom the eligible children live, unless such parent has incurred a penalty of ineligibility (see N.J.A.C. 10:69-10.28), is an SSI beneficiary, is an ineligible alien (see N.J.A.C. 10:69-3.9) or is an AFDC-C related Medicaid program beneficiary parent who married on or after October 1, 1992 and is excluded from AFDC-related Medicaid program eligibility in accordance with the provisions of N.J.A.C. 10:69-10.33.

(e) If a natural or adoptive AFDC-C related Medicaid program beneficiary parent

marries a non-needy individual who is not the natural or adoptive parent of one or more of the related Medicaid program beneficiary parent's children prior to October 1, 1992. The provisions are in N.J.A.C. 10:69-10.33.

10:69-10.5 Eligible unit; AFDC-C and -F related Medicaid program

(a) The AFDC-C related Medicaid program shall include:

1. The natural or adoptive parent(s) of one or more of the eligible child(ren) unless the AFDC-C related Medicaid program beneficiary parent marries on or after October 1, 1992 and is excluded from AFDC-related Medicaid program eligibility in accordance with the provisions of N.J.A.C. 10:69- 10.34;

2. The stepparent (the spouse of a natural or adoptive parent) of the children for whom AFDC-related Medicaid program is sought may be included in the eligible unit if the provisions of N.J.A.C. 10:69-2.9 apply. If a non- needy stepparent marries the AFDC-C related Medicaid program beneficiary parent on or after October 1, 1992, and the provisions of N.J.A.C. 10:69- 2.11 apply, the stepparent, the stepparent's natural or adoptive children as well as the natural or adoptive parent of the AFDC-C related Medicaid program beneficiary children are excluded from the eligible unit;

3. An enumerated parent-person and his or her spouse, when such individuals claim to be financially eligible; and

4. When the child(ren) lives with a parent-person who is not himself or herself applying for AFDC-related Medicaid program and a natural or adoptive parent is not in the home, only the eligible child(ren) comprises the eligible unit.

(b) The AFDC-F related Medicaid program shall include the natural or adoptive parents with whom the eligible child(ren) lives when both parents are in the home, are not incapacitated and the parent who is the principal earner meets the Federal definition of unemployment.

(c) A child not meeting AFDC-related Medicaid program age requirements is not eligible for AFDC-C or -F and shall not be included in the eligible unit. For determination of Medicaid eligibility for such children under the age of 21, see N.J.A.C. 10:69-4.

(d) When an applicant for AFDC-C-related Medicaid program must wait for incapacity to be established, eligibility shall be considered for AFDC-F or -N- related Medicaid program.

10:69-10.6 Eligible unit; AFDC-N related Medicaid program

(a) The eligible unit for the AFDC-N-related Medicaid program shall include the two natural or adoptive parents and their eligible children under 18 years of age and any child age 18 if a full-time student in a secondary school, or in the equivalent level of vocational or technical training, and reasonably expected to complete the program before reaching age 19. If one parent has children of his or her own living in the home,

the following shall apply:

1. When a parent has children of his or her own, this parent, this parent's spouse, and this parent's child(ren) may be eligible for the AFDC-C-related Medicaid program. The needs of the remaining eligible members of the unit shall be met according to -N-related Medicaid program related Medicaid program standards. (See N.J.A.C. 10:69-10.35 for budgeting companion cases.)

2. The same potential for eligibility under AFDC-C-related Medicaid program may apply to each parent in his or her own right, in which event only their joint children shall be AFDC-N-related Medicaid program eligibles.

(b) A child not meeting program age requirements is not eligible for AFDC-N and shall not be included in the eligible unit. See N.J.A.C. 10:69-4 for possible Medicaid Special eligibility.

10:69-10.7 Eligible person temporarily in an institution

(a) A member of the eligible unit who is temporarily in an institution in accordance with N.J.A.C. 10:69-3.29 shall continue to be regarded as an eligible member of that unit.

(b) When the absence of an AFDC-N-related Medicaid program parent will continue for 30 days or longer, the remaining members of the family may be eligible for AFDC-C-related Medicaid program.

10:69-10.8 Eligible AFDC child or parent regularly attending school or in vocational training at a Residential Job Corps Center

(a) When an eligible child is a student regularly attending school, college or university, or regularly attending a course of vocational training designed to fit him or her for gainful employment, this child shall be included as a member of the eligible unit whether or not he or she is living in the home during the period in which he or she is pursuing his or her studies. (See N.J.A.C. 10:69-10.9 for definitions of school attendance.)

(b) Any grant, scholarship, student loan or other financial aid received by such child shall be fully disregarded in determining eligibility so long as the child continues to attend school as stated in (a) above and meets the conditions under which such moneys are granted.

1. Funds received through college work-study programs shall be disregarded.

(c) When a child receives vocational training at a Residential Job Corps Center which permits him or her to return home for weekends, the child shall be considered temporarily absent and regarded as an eligible member of the family unit. (A child receiving training at a National Job Corps Centers is to be considered permanently absent and shall not be considered a member of the eligible family for AFDC-related Medicaid program eligibility.)

10:69-10.9 School attendance defined

(a) A child eligible under the age requirements of N.J.A.C. 10:69-3.13 shall be considered a student regularly attending a school or training course when he or she is enrolled in and physically attending, as certified by the school or institute, a program of study or training leading to a certificate, diploma or degree:

1. Full time;
2. At least half-time and is regularly employed part-time or is available for and actively seeking part-time employment; or
3. At least half-time and is precluded from full-time attendance or part- time employment because of a verified physical disability.

(c) Full-time and half-time attendance are defined as:

1. In a trade or technical school, in a program involving shop practice, full-time is 30 clock hours per week and half-time is 15 clock hours; in a program without shop practice, full-time is 25 clock hours and half-time is 12 clock hours;
2. In a college or university, full-time is 12 semester or quarter hours and half-time is eight semester or quarter hours;
3. In a secondary school, full-time is 25 clock hours per week or four Carnegie units per year and half-time is 12 clock hours or two Carnegie units; and
4. In a secondary education program of cooperative training or in apprenticeship training, full-time attendance is as defined by the State Department of Education.

(d) When a parent of an eligible child is a student regularly attending school as defined in this section, the provisions of N.J.A.C. 10:69-10.8(b) and (c) shall apply.

(e) A child shall be considered in regular attendance in months in which he or she is not attending because of official school or training program, vacation, illness, convalescence or family emergency, and for the month in which he or she begins, completes or discontinues his or her school or training program.

10:69-10.10 General provisions--income

(a) Income may be earned, unearned or in the form of contributions.

(b) Earned income shall not include the amount of Earned Income Credit payment that an individual receives.

10:69-10.11 Definition of earned income

(a) Earned income refers to gross income earned by an individual through the receipt of wages, tips, salaries or commissions from activities in which he or she is engaged as an employee or from his or her self-employment. It includes earnings over a period of time for which settlement is made in one payment, as in the sale of farm crops.

(b) When an individual receives shelter in return for performing work duties, the monetary value shall be determined from Schedule VI in N.J.A.C. 10:69- 10:42(c) and included in the total amount of gross earned income. The amount of mandatory payroll deductions to be recognized shall be determined in relation to such total amount.

(c) When an individual is employed in a position where tipping is customary, a daily log or other acceptable documentation of tips received shall be used for income calculation. Tips income calculation shall not be based on estimated information as reported on W-2 forms.

10:69-10.12 Earned income from self-employment including provisions of personal care services

(a) With respect to self-employment, the term "earned income" means the total profit from a business enterprise (such as farming) resulting from a comparison of the gross receipts with the business expenses. Business expenses are those costs directly related to producing the goods or services and, without which, the goods or services could not be produced. However, items such as depreciation, personal business and entertainment expenses, personal transportation, purchase of capital equipment, and payments on the principal of loans for capital assets or durable goods are not business expenses.

1. Persons who are self-employed shall be required to submit evidence of business receipts and expenditures as the basis for a sound estimate of earned income. A reliable, accurate accounting system or the method utilized in reporting to the Internal Revenue Service shall be acceptable for determining net income.

(b) In the case of an individual who is self-employed, it may be clearly evident that the expense of producing the income exceeds the income produced. AFDC-related Medicaid program shall not be continued if such person persists in operating the business.

1. A period of up to 24 months from the start of a new business shall be considered adequate to demonstrate a new business's potential for self- support. In situations where, in the judgment of the county board of social services, additional time would enable the business to show a profit, the period may be extended up to 12 months.

2. A business which is already established (that is, in operation for at least 36 months) and which shows only marginal profit, either constant or intermittent, shall be considered for purposes of AFDC-related Medicaid program eligibility to be failing if the profit, averaged over the preceding 12 months, is less than $375.00 per month.

(c) An individual who is providing extensive personal services along with room and board accommodation to a noneligible individual shall be considered self-employed. An amount of $125.00 shall be recognized as the business expense and cost of providing room, board and extensive personal services. Any income from this arrangement in

excess of $125.00 shall be recognized as earned income.

10:69-10.13 Earned income disregards for AFDC-C and AFDC-F related Medicaid

(a) The CBOSS shall disregard from the earned income of each employed individual in the eligible family, the first $90.00 of such earnings to cover work-related expenses including, but not limited to, transportation and mandatory payroll deductions.

(b) The CBOSS shall disregard from the total earned income not already disregarded, an amount equal to the difference between 133 percent of the Federal poverty level (see 42 C.F.R. 9902(2)) and the Income Standard established for the size of the family unit, in accordance with the chart at N.J.A.C. 10:69-10.3(b) as follows:

1. For beneficiaries eligible on and after June 15, 2002, regardless of date of application; and
2. For applicants who apply on and before June 14, 2002 with a disposition pending.

(c) For applications received on and after June 15, 2002, the CBOSS shall disregard from the total earned income not already disregarded, the first $30.00 and one-third of the remainder for each employed individual.

1. This disregard shall apply to the earned income of a person for a period of four consecutive months. Once this disregard has applied for a four consecutive month period, it shall not again be applied on behalf of that individual as long as he or she continues to receive AFDC-related Medicaid expansion as described in (b) above. If, after receiving this disregard for a 12-month period, the individual becomes ineligible for AFDC-related Medicaid or Medicaid expansion, this disregard shall not be applied to his or her income unless the individual has remained ineligible for AFDC-related Medicaid or Medicaid expansion for a period of 12 consecutive months.
2. For any month in which any part of the $30.00 and one-third disregard is applied, that month shall be counted as one of the four consecutive months of disregard.
3. Any month for which the individual loses the $30.00 and one-third disregard because of a provision in (e) below shall be considered as one of the four consecutive months.
4. For a period not exceeding eight months from the end of the four consecutive months of the $30.00 plus one-third of the remainder disregard, a deduction of the first $30.00 of the remaining income shall be applied.
   i. Upon expiration of the eight-month period this deduction shall not be applied again so long as the wage earner is a beneficiary of AFDC-related Medicaid or Medicaid expansion. This deduction shall again be applied after the eight-month period only after the wage earner has not been a beneficiary of AFDC Medicaid or Medicaid expansion for a period of 12 consecutive months.
5. When an AFDC-related family loses eligibility for AFDC-related Medicaid, due to the following reasons, the disregard in (b) above shall apply:
   i. Earnings or increased earnings from employment, including earnings from new

employment;

ii. Expiration of the $30.00 or one-third disregards of earned income because of the time-limited application of those disregards; or

iii. Increased hours of employment.

(d) The CBOSS shall disregard from the remaining earned income, the actual costs paid for child care or for care of an incapacitated individual in the same home as the AFDC-C, -F or -N eligible family when the circumstances described at (d) below exist. The amount of the disregard shall not exceed the limits as follows.

1. $175.00 per month, per child age two or older, or incapacitated adult, for full-time employment;
2. $200.00 per month, per child under age two, for full-time employment;
3. $135.00 per month, per child age two or older, or incapacitated adult, for part-time employment; and
4. $150.00 per month, per child under age two, for part-time employment.

(e) None of the disregards above shall apply to the earned income of the individual for any month which one of the following conditions apply to him or her:

1. His or her employment is terminated or his or her earned income is reduced without good cause within 30 days prior to that month.

i. Good cause includes the following circumstances:

(1) The termination or reduction is not voluntary;
(2) The wages of employment are below the applicable minimum wage;
(3) The individual is not physically able to engage in the employment;
(4) The employment constitutes a risk to health or safety; or
(5) The applicant voluntarily requested AFDC-related Medicaid be terminated for the primary purpose of avoiding the receipt of the $30.00 and one-third disregard for four consecutive months.

(f) The earned income disregard of a full-time or part-time student is described in N.J.A.C. 10:69-10.15.

(g) None of the disregards above in this section shall apply to the earned income of the individual for any month in which one of the following conditions apply to him or her:

1. The individual terminated his or her employment or reduced his or her earned income without good cause within 30 days prior to that month.

i. Good cause includes the following circumstances:

(1) The termination or reduction is not voluntary;
(2) The wages of employment are below the applicable minimum wage;
(3) The individual is not physically able to engage in the employment; and
(4) The employment constitutes a risk to health or safety.

2. The individual refused without good cause, within 30 days prior to that month, to

accept employment in which he or she is able to engage which is offered through the State Division of Employment Security or any other bona fide offer of employment. The good cause provisions of (f)1i above apply.

3. The individual voluntarily requested AFDC-related Medicaid program coverage to be terminated for the primary purpose of avoiding the receipt of the $30.00 and one-third disregard for four consecutive months.

10:69-10.14 Disregard of certain allowances and payments in AFDC-related Medicaid program (all segments) for participation in JTPA

(a) Unearned income (including moneys to offset training expenses) received by an AFDC dependent child through the Job Training Partnership Act (JTPA) is exempt in the determination of initial eligibility, maximum income eligibility, and prospective needs test.

(b) Earned income received through the JTPA by an AFDC-related Medicaid program dependent child is exempt in the determination of initial eligibility, maximum income eligibility, and prospective needs test. However, the disregard of such income shall not exceed six months in any calendar year.

1. This disregard of income is independent of the earned income disregard found at N.J.A.C. 10:69-10.8 and 10.15. If a full-time student secures employment unrelated to JTPA participation, another six-calendar-month period shall be established in accordance with the provisions of N.J.A.C. 10:69- 10.15(g).

(c) Income received by an AFDC-related Medicaid program parent or parent- person through the JTPA is treated as any other income received by such an individual with the exception of those payments classified as "needs based payments." Needs based payments (that is, moneys paid to offset expenses related to training) shall be disregarded in the determination of initial eligibility, maximum income determination, and prospective needs test.

10:69-10.15 Earned income disregards of a child who is a full or part-time student

(a) The earned income of any child in the eligible unit who is a full-time student, or is a part-time student who is not a full-time employee, shall be exempt in determining need of the eligible unit and in evaluating his or her capacity as a legally responsible relative. (See N.J.A.C. 10:69-10.9 for definitions of full and part-time students.)

(b) For the purposes of this section, a full-time employee shall be any student whose average employment on a monthly basis equals 35 hours a week or more.

(c) A student who is a full or part-time student during the regular school term shall be considered to be a full or part-time student during all vacation periods.

(d) When a child claiming the exemption of earned income described in this section is

over 16 years of age, this student shall be informed in writing that he or she has a responsibility for participating in determining his or her eligibility for such exemption. The student and the county board of social services have joint responsibility for securing the factual data from the school necessary to make the determination as to whether he or she is a full or part-time student, and for securing from his or her employer the factual data of monthly hours employed.

(e) Part-time students who are fully employed and are thus not eligible for the exemption of earned income as described in this section are eligible for the appropriate disregards depending on program related Medicaid program.

(f) The exemption of earned income of part-time students under this section does not apply in determining maximum income eligibility in N.J.A.C. 10:69- 10.3.

(g) The earned income of a full-time student shall be disregarded in the determination of maximum income eligibility (N.J.A.C. 10:69-10.3) for a total of six months in any one calendar year.

10:69-10.16 Income from family day care

(a) Payments by individuals or agencies for children placed in an eligible family's home for family day care shall be considered as gross earned income from self-employment. Earned income procedures for self-employment are discussed at N.J.A.C. 10:69-10.12.

1. The net income (adjusted gross earnings) to the eligible family is the difference between the cost of providing family day care and the total monthly amount paid for such care. Appropriate disregards apply in determining the calculated earned income (see N.J.A.C. 10:69-10.13).

10:69-10.17 Division of Youth and Family Services payments for foster care

(a) Division of Youth and Family Services' basic monthly payments for the placement of children in foster care and the clothing allowance shall be considered as equal to the cost of providing such care and maintenance. However, when extra payment is received for special services, such additional amount shall be considered as earned income from self-employment (see N.J.A.C. 10:69-10.13).

(b) For purposes of determining AFDC-related Medicaid program eligibility, such foster care children are not considered members of the eligible unit.

10:69-10.18 Income which is not earned

Net income from noneligible household members (except as stated in N.J.A.C. 10:69-10.12(c)), returns from capital investment such as dividends and interest, benefits and pensions, annuities, contributions from relatives, compensation payments, and any other payments not considered as earned income, shall be considered as unearned

income. All such income shall be recognized in establishing eligibility.

10:69-10.19 Income from roomer-boarders and table boarders

Roomer-boarders or table boarders are noneligible household members.

10:69-10.20 Income from apartments, rooms or housekeeping units in the eligible unit's home

(a) When the eligible unit is receiving payment from rental of apartments, rooms or housekeeping units, the net income shall be determined by deducting the costs of operation and maintenance from the gross rental income received.

1. The costs of operation and maintenance are the greater of:

i. The actual costs of operation and maintenance, if known or subject to determination, or such reasonable allocation of actual or determined costs as may be indicated according to the space being rented out; or

ii. The number of rooms, excluding bathrooms, being rented out multiplied by the applicable monthly cost figure as follows:

(1) With no utilities: $23.00;

(2) Including heat only: $29.00;

(3) Including all utilities: $34.00.

2. To determine the total cost, multiply the monthly cost figure by the number of rooms in each apartment or housekeeping unit, excluding any room used solely as a bathroom.

3. Deduct the total cost from the amount of rental income received by the eligible unit. The difference is the net income.

i. Rental income shall be treated as earned income except in those situations where rental properties are in the hands of rental agencies; in such case, the income shall be considered as unearned.

(b) When the functions of property management including the collection of rents are performed by a member(s) of the eligible unit, the net is earned income; otherwise it is unearned income.

10:69-10.21 Contributions of support

(a) Obligatory contributions to the support of one or more members of the eligible unit shall be recognized as unearned income, regardless of whether such contributions are in cash or in kind. (See N.J.A.C. 10:69-10.42, Acceptable forms of support.)

(b) When shelter is being provided by a legally responsible relative (LRR) who has been determined by the CBOSS IV-A unit to have a capacity to provide support, the actual cash value shall, whenever possible, be determined and recognized as unearned income to the eligible unit. Where the actual value cannot be established, and is not stipulated by a court order to be made in an identifiable cash amount to a third party, the

monthly monetary values shall be recognized according to Schedule VI in N.J.A.C. 10:69-10.42(c) and shall not exceed the LRR's evaluated capacity.

(c) Non-obligatory contributions, other than occasional gifts identified in N.J.A.C. 10:69-3.2, shall be recognized as unearned income only when made in cash to one or more members of the eligible unit (see also N.J.A.C. 10:69- 2.2). This does not apply to LRRs who have an evaluated capacity to support.

10:69-10.22 Exempt income

(a) Exempt income is not considered in determining eligibility for AFDC- related Medicaid program.

(b) Income shall be exempted as follows:

1. Income tax refunds, including Homestead Property Tax Rebates;
2. Earned income credit (EIC) payments shall be excluded.
3. Payments for child care (see N.J.A.C. 10:69-5).
4. Child care payments for "special circumstance" children and transportation or the cost of transportation, which is not available from any other source, to transport the "special circumstance" child to and from the child care site when it is essential for the child's physical health and safety.
5. Supplemental aid by other agencies or organizations, whether public or private, provided that:
   i. There is no duplication between such aid and the TANF grant;
   ii. Such aid is for a special purpose not within the function of the public assistance agency (for example, vocational rehabilitation); or
   iii. Such aid is to any undergraduate student for educational purposes.
6. Any income received through the Subsidized Adoption Program of the Division of Youth and Family Services pursuant to N.J.S.A. 30:4C-45 through 49 (P.L. 1973, c.81).
7. Funds received by applicants and beneficiaries through certain Federal programs shall be regarded as exempt income.
   i. Benefits or assistance received through the WIC program (Special Supplemental Food program for Women, Infants and Children) and the special food services program for children under the National School Lunch Act as amended by Public Laws 92-433 and 93-150;
   ii. Benefits received under Title VII, Nutrition Program for the Elderly, of the Older Americans Act of 1965;
   iii. Payments made through Service Corps of Retired Executives (SCORE), Active Corps of Executives (ACE), and payments made under Title I of P.L. 93-113 (for example, Volunteers in Service to America (VISTA));
   iv. Payments received under the Experimental Housing Assistance Program (EHAP) made under annual contribution's contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1937;

v. Payments made through the United States Department of Housing and Urban Development (HUD) Section 8, Rental Assistance Program (RAP), which provides funds to certain disabled individuals and low income families to assist them in meeting shelter costs;

vi. HUD community development block grant funds under Title I of the Housing and Community Development Act of 1974;

vii. Benefits received by eligible households under the Low Income Home Energy Assistance Act of 1981 pursuant to section 2605(f) of Public Law 97-35.

8. The value farm and garden products raised by the eligible unit for its own use is not considered income.

(c) Occasional nonrecurring gifts and contributions of nominal amount or value, such as those for birthdays, graduations, Christmas or other holidays, to the extent the value does not exceed an average of $30.00 per beneficiary in any calendar quarter, are considered exempt income.

1. In cases where such gifts and contributions exceed an average of $30.00 per beneficiary in any calendar quarter, that excess shall be counted as unearned income.

2. In determining value, a gift received by one member of the eligible unit but intended for the entire eligible unit may be allocated among the eligible unit members in the way most advantageous to the entire unit.

10:69-10.23 Nonrecurring earned or unearned lump sum income

(a) When a beneficiary receives nonrecurring earned or unearned lump sum income, including retroactive RSDI payments and other monthly benefits, and payments in the nature of a windfall, such as inheritances and lottery winnings, personal injury and worker compensation awards, to the extent it is not earmarked and used for the purpose for which it was paid (for example, moneys for back medical bills resulting from accidents or injury, funeral and burial costs, or replacement or repair of resources), that income will be added together with all other income received that month by the eligible family after application of the disregards in N.J.A.C. 10:69-10.32 and the exemption of income in N.J.A.C. 10:69-10.31. The TANF grant shall not be considered income. When this total exceeds the standard of need for the eligible family size as set forth at N.J.A.C. 10:69-10.2, the family shall be ineligible for AFDC-related Medicaid program for the number of full months derived by dividing this total income by the standard of need applicable to the eligible family. Any remaining income from this calculation is treated as if it is unearned income received in the first month following the period of ineligibility and is considered available for use at that time. SSI payments shall not be subject to lump sum treatment.

1. For purposes of determining the period of ineligibility, the family includes the AFDC-related Medicaid program eligible unit and any other individual (such as a stepparent) whose lump sum income caused the unit's income to exceed the allowance standard.

2. The period of ineligibility shall begin in the first month subsequent to the month the

nonrecurring income is received or, if there is insufficient time for a timely adverse action notice, the following month.

3. In the event the nonrecurring income is not reported timely, the period of ineligibility shall begin at the point the ineligibility would have occurred had the CBOSS had knowledge of its receipt. The amount of Medicaid overpayment for the period of ineligibility must be established and recovery made.

4. The period of ineligibility applies to each individual in the eligible family at the time of receipt of the lump sum nonrecurring income. Other family members to whom the penalty does not apply, may be eligible as a separate Medicaid eligibility unit.

5. Once established, the period of ineligibility may be reduced only in the circumstances below. It is the responsibility of the former eligible family to provide all necessary information and documentation required to make a determination to shorten the period of ineligibility. The basis for a determination to shorten the period of ineligibility shall be thoroughly documented in the case record.

i. The period of ineligibility may be recalculated when the AFDC standard of need is increased. Upon request of a former AFDC eligible family, the period of ineligibility shall be reduced as follows:

(1) The number of months of ineligibility already elapsed shall be multiplied by the standard of need used to compute the original period of ineligibility;

(2) The result shall be subtracted from the original lump sum amount; and

(3) The remaining amount shall be divided by the new AFDC standard of need for the eligible family size and the result will be the number of months of ineligibility remaining.

ii. The period of ineligibility may be recalculated if the income used to determine such period becomes unavailable to the eligible family for reasons beyond the control of the family members. Acceptable reasons are limited to those below:

(1) The former eligible family shall thoroughly substantiate an allegation of loss or theft of part or all of the lump sum income and shall provide the CBOSS with evidence that a police report of an incident of theft has been filed. Upon receipt of credible evidence of loss or theft of the income, the CBOSS shall reduce the amount of the original lump sum by the amount of the loss or theft. Loss of the income, for the purposes of this section, shall include circumstances where a member of the former eligible family has absconded with the funds.

(2) When the former eligible family incurs and pays verifiable expenses due to an emergent situation, including fire, flood, natural disaster or other emergent situation, for which, had the family been eligible, emergency assistance would have been authorized under N.J.A.C. 10:90, those expenses shall reduce the amount of the original lump sum.

iii. The period of ineligibility may be reduced if the family incurs, becomes responsible for, and pays medical expenses during the period of ineligibility. In such cases, the original income used to compute the period of ineligibility shall be offset by verified medical expenditures. For this purpose, allowable medical expenses are as follows:

(1) Medical and dental care including psychotherapy and rehabilitation services

provided by a licensed practitioner authorized by State law or other qualified health professional;

(2) Hospitalization or outpatient treatment, nursing care, and nursing home care, including payments by the household for an individual who was an eligible family member immediately prior to entering a hospital or nursing home, provided by a facility recognized by the State;

(3) Prescription drugs when prescribed by a licensed practitioner authorized under State law and other over-the-counter medication (including insulin) when approved by a licensed practitioner or other qualified health professional; in addition, costs of medical supplies, sick-room equipment (including rental) or other prescribed equipment;

(4) Health and hospitalization insurance policy premiums;

(5) Medicare premiums related to coverage under Title XVIII of the Social Security Act;

(6) Dentures, hearing aids, and prosthetics;

(7) Securing and maintaining a seeing eye or hearing dog including the cost of dog food and veterinarian bills;

(8) Eye glasses prescribed by a physician skilled in eye diseases or by an optometrist;

(9) The reasonable cost of transportation and lodging to obtain medical treatment or services; and

(10) Maintaining an attendant, homemaker, home health aid, housekeeper, or child care services, necessary because of age, infirmity, or illness.

6. In all instances, where the previously eligible family has been terminated due to receipt of lump sum income, the notice of adverse action shall include:

i. The reason for the family's termination from AFDC-related Medicaid program;

ii. The duration of the period of ineligibility;

iii. The earliest date the ineligible family may apply to reopen their AFDC- related Medicaid program case; and

iv. A statement concerning possible reduction of the ineligibility period (see (a)5ii or iii above).

(b) For the AFDC-related program, lump sum income and the resulting period of ineligibility shall be treated in accordance with the following provisions:

1. Only those individuals actually receiving AFDC-related Medicaid or Medicaid Special are considered to be AFDC-related Medicaid program beneficiaries. Any individual receiving Medicaid Only, New Jersey Care ... Special Medicaid programs, Medicaid Special, NJ KidCare or any other medical coverage is not considered an AFDC-related Medicaid program beneficiary. Therefore, a period of ineligibility imposed on a beneficiary of Medicaid Only or Medicaid Special benefits due to the receipt of lump sum income cannot be carried over into the AFDC-related Medicaid program, and cannot cause ineligibility for AFDC-related Medicaid program benefits.

(c) This section is not to be construed to limit any policy pertaining to reimbursement in any program but must be applied in conjunction with any repayment agreement.

(d) No portion of a cash reward provided to any individual by the Division for providing information about fraud and/or abuse in any program administered in whole or in part by the Division shall be included in the computation of income for financial eligibility purposes.

10:69-10.24 Child support received by the eligible unit

The first $50.00 of any child support payments received on behalf of a dependent child or children by any family applying for or eligible for AFDC- related Medicaid program shall be disregarded. Such child support payments shall include disregarded child support (DCS) payments paid the family through the child support and paternity process and direct support payments received by the eligible unit which represent a current monthly support obligation. These moneys are disregarded in determination of initial eligibility, maximum income eligibility, and the prospective needs test. The total amount of child support disregarded shall not exceed $50.00 per month per eligible unit.

10:69-10.25 Prospective budgeting

(a) Prospective budgeting policy shall be applied to applicants and beneficiaries of AFDC-related Medicaid program benefits, including Medicaid Special.

(b) AFDC-related Medicaid program eligibility shall be based on a best estimate of the family's income and other circumstances that will exist until the next reported significant change in circumstance or redetermination, whichever is first. The best estimate of income is based on the family's and the agency's reasonable expectations and knowledge of current, past, and future circumstances. In determining the best estimate of income, the CBOSS shall use income averaging and the concept of "significant and non-significant" income and circumstance changes. Verification of the income used shall be clearly documented in the case record.

1. For purposes of determining the family's eligibility, the CBOSS shall determine earnings by obtaining wage information for the four consecutive week period immediately preceding the date of application, redetermination, or change in circumstance. Likewise, all unearned income received within this four-week period is also determined. All earned and unearned income received within this four week period shall be verified and documented in the case record, even if all four weeks of income are not ultimately used to calculate the best estimate.

2. The receipt of income generally occurs weekly, biweekly, or on a semi- monthly basis. The CBOSS shall convert the averaged income amount to a gross monthly amount by multiplying the averaged income amount by the appropriate conversion factor as follows: weekly amounts by 4.333; biweekly amounts by 2.167; and semi-monthly amounts by two.

(c) Significant income and circumstance changes are defined as changes in sources or amounts of earned or unearned income or changes to the eligible unit size which are expected to continue into the future. Examples of significant changes include, but are not limited to: starting a new job or gaining a new source of unearned income; losing a job or a source of unearned income; permanent or long term changes in hours worked and/or rate of pay; permanent or long term changes in unearned income; changing from part-time to full-time employment (or vice versa); promotion or demotion; beginning to work piece work or regular overtime (or vice versa); changing employers; short term plant closings (such as one or more weeks) or periods of sick leave without compensation (more than one day); or addition of or loss of an eligible family member.

1. The CBOSS shall use information about past significant changes of a continuous nature in estimating future income. The date of an anticipated significant income/circumstance change may be used to schedule a desk review to coincide with the expected date of the change, in order to recalculate the best estimate of income.

2. Families shall be required to report all significant changes in income and circumstances that could affect eligibility as soon as possible, but in no event later than 10 calendar days of the date the change happened. The CBOSS shall initiate appropriate action on the reported change within 10 calendar days of receiving the report of the change, subject to timely and/or adequate notice requirements.

(d) Non-significant income/circumstance changes are defined as temporary, very short term variations in the earned or unearned income amount or eligible unit size caused by a situation which is not of an ongoing nature, or which is of a variable nature. Examples include, but are not limited to: fluctuations in wages due to ongoing (reported) earnings from piece work; occasional changes in wages due to very irregular overtime; or an occasional unpaid day off.

(e) The following procedures are to be followed in determining the best estimate of income:

1. Verification through wage stubs or documentation from the employer, of income received within the specified time frame in (b) above. All earned and unearned income received within this four week period shall be verified and documented in the case record even if all four weeks of income are not ultimately used to calculate the best estimate.

2. Determination, through a review of the income documentation and discussion with the family, if there have been any significant changes during that period. If a significant change has occurred and the change is of a continuous nature, the change shall be documented and taken into consideration when determining the best estimate. For example, if a family has received an increase in hourly rate, the new hourly rate shall be multiplied by the appropriate number of hours (either stable or averaged) to determine anticipated income.

3. Determination of any significant changes that are expected in the future. If a significant change is expected and the exact nature of the change is known, the CBOSS shall use the information in determining the best estimate of income and shall require that the family provide the required verification subsequent to the change to determine if the best estimate was correct or needs to be recalculated. If the exact nature of the anticipated change is not known, then a desk review can be scheduled to coincide with the expected date of change and/or the client advised to report the change within 10 days of the date of change.

4. Determination, through review of the documentation, of the case record and discussion with the client, if any of the income received is not expected to be representative of the future. For instance, the first pay check of new employment may not represent a full-pay period; a missing week's income may represent a summer plant closing; or a larger check may represent nonrecurring overtime, all of which may not be anticipated to occur in the future. Non-representative income (or lack of income) shall not be used in calculating the best estimate. The case record shall be clearly documented to explain why any income was not used, and to show how the best estimate was calculated. For example, the family receives regular weekly income but is missing one week's pay due to a plant closing for that week only. The three available amounts would be averaged to determine average weekly income and that average converted to monthly gross income as described in (b)2 above.

5. If income fluctuates (that is, is not exactly the same each time received and/or is not received on a regular schedule) to the extent that a four-week period is not expected to provide the best estimate of income until the next redetermination, the CBOSS shall require the family to submit verified wage information for those months subsequent to the month of review, in order that the CBOSS may recalculate the best estimate. When income fluctuates dramatically, CBOSSs shall recalculate eligibility as often as deemed necessary to ensure the most accurate best for determination of continued AFDC-related Medicaid eligibility.

i. When four consecutive weeks of income fluctuate but are representative of the family's anticipated fluctuation in income for future months, the CBOSS shall average the income from the four-week period and project that gross income estimate for future months, taking into account any anticipated significant changes.

6. The final step shall be to average the income that has been determined to be representative of the eligible family's circumstances and to convert that average to a gross monthly income "best estimate" amount by using the conversion factors set forth in (b)2 above. The best estimate amount shall then be used to determine eligibility until the next redetermination or report of a significant change.

(f) If there are no significant changes in circumstances, a new best estimate of income shall, at a minimum, be completed at the time of the next redetermination of eligibility.

1. When non-significant changes are reported, it shall not be necessary to redetermine eligibility immediately. Non-significant changes shall, however, be taken

into consideration when determining the best estimate of income at the next regularly scheduled redetermination. When such changes are reported, the case record shall be clearly documented to show that the change was non- significant.

2. A significant change in circumstances of the eligible family may result in loss of eligibility. The termination of eligibility shall be effective no later than the first day of the month following the month in which the significant change in circumstance occurred, or 10 business days after the change is reported to the CBOSS, whichever is later. Termination of eligibility shall be subject to timely and adequate notice and meet the requirements of N.J.A.C. 10:69-6.

10:69-10.26 Eligibility

(a) In determining initial eligibility, the appropriate disregards shall be applied to earned income.

(b) The effective date of initial eligibility shall be the first day of the month of the date of the application if the client was eligible on the date of application. If the client was found eligible on any other date, initial AFDC- related Medicaid eligibility shall be retroactive to the first day of the month the date eligibility commenced.

10:69-10.27 Income from eligible and noneligible individuals in the household

(a) For purposes of AFDC-related Medicaid program, in family groups living together, income of the spouse is considered available for the other spouse and income of a parent (natural or adoptive) is considered available for children under 18. If the spouse or parent is living with his or her spouse or children, respectively, income is considered available regardless of whether the spouse or natural or adoptive parent is noneligible. However, if a spouse or parent is receiving SSI benefits, including mandatory or optional State supplementary payments, then for the period for which such benefits are received, his or her income shall not be counted as income available to the eligible family.

(b) A noneligible individual is neither sanctioned nor required by law or regulation to be included in the eligible unit. When a noneligible individual is living in the household of an eligible unit, the income from that living arrangement to the eligible unit shall be treated in accordance with N.J.A.C. 10:69-10.3, if extensive personal services are provided, or N.J.A.C. 10:69-10.20. If the non-eligible individual is a non-qualified alien parent (see N.J.A.C. 10:69-3.9), his or her income shall be considered available to the eligible unit and shall be calculated in accordance with the step-parent deeming formula in N.J.A.C. 10:69-10.33 and 10.34.

10:69-10.28 Penalty of ineligibility for CSP sanction

(a) An adult sanctioned for failure to cooperate with the child support and paternity requirements is not included in the eligible unit. When the adult is not included in the

eligible unit because of this sanction and has earned or unearned income of his or her own, such income shall be considered available to the remaining members of the eligible unit.

1. For earned income, the net amount to be considered available to the eligible unit shall be determined without application of earned income disregards set forth in N.J.A.C. 10:69-10.10 through 10.23.

10:69-10.29 Needs of certain children temporarily in the home

When an institutionalized child is on temporary visit home (and an AFDC- related Medicaid program eligible case is not in existence), he or she may be eligible for General Assistance if the visit does not exceed 21 consecutive days. If the length of such child's visit is expected to exceed 21 days, the CBOSS shall process an AFDC-related Medicaid program application and evaluate the family's eligibility for AFDC-related Medicaid program for the duration of the visit.

10:69-10.30 Initial eligibility and application of disregards

(a) On all new applications, reapplications, or reopened applications, initial financial eligibility must be established before a AFDC-N-related Medicaid card can be issued.

1. For AFDC-C, -F and -N related Medicaid cases, when the eligible family received AFDC-related Medicaid program assistance in one of the four months prior to the month of application, all earned income disregards at N.J.A.C. 10:69-10.13 shall apply to the determination of initial eligibility. For AFDC-C, -F and -N-related Medicaid cases which have not received AFDC-related Medicaid benefits in one of the four months prior to the month of application, the earned income disregards apply, except that the disregard of the first $30.00 of the remaining income plus one-third of the remainder does not apply. If total income equals or exceeds the income standard in N.J.A.C. 10:69-10.21 for the eligible family size, the family is ineligible for Medicaid. In the computation of initial Medicaid eligibility, application of the $30.00 and one-third earned income disregards is subject to the limitations at N.J.A.C. 10:69-10.16.

2. The earned income of a full-time student shall be disregarded in determining initial Medicaid eligibility to the same extent as provided in N.J.A.C. 10:69-10.15. The income of a part-time student is not disregarded in determining initial eligibility.

10:69-10.31 Procedures for determining initial eligibility for AFDC-C, -F and -N related Medicaid

(a) The procedures regarding initial income eligibility are:

1. Identify the number of persons in the eligible unit; and

2. Determine the total monthly income (including gross earned income) available to the eligible unit and compare it to the maximum income level in N.J.A.C. 10:69-10.3 (Exception: For a non-needy stepparent who marries an AFDC-C related Medicaid beneficiary parent on or after October 1, 1992, eligibility for the children shall be determined in accordance with the regulations at N.J.A.C. 10:69-10.33 or 10.34 as

applicable.) If total income equals or is less than the maximum for the appropriate eligible unit size, maximum income eligibility has been established. If total income exceeds the appropriate maximum for any month, the family is not eligible for AFDC-related Medicaid program.

10:69-10.32 (Reserved)

10:69-10.33 AFDC-C procedures for stepparents

(a) When a stepparent of eligible AFDC-C-related Medicaid program children is in fact a member of the household and has married the natural or adoptive beneficiary parent, the natural or adoptive parent who is applying for or receiving AFDC-related Medicaid program shall be afforded the following elective options:

1. The stepparent may be included as a member of the eligible unit, with all needs recognized and his or her income considered in determining AFDC-related Medicaid eligibility.
2. The stepparent may not be included in the eligible unit, in which case the income of the stepparent shall be treated in accordance with (d) below.

(b) The options and all consequences thereof shall be fully discussed with the applicant before the decision is made. The decision as to whether the stepparent shall be included (assuming the stepparent is so willing) or excluded shall be made by the natural or adoptive parent.

(c) When the stepparent who has married the AFDC-C-related Medicaid program beneficiary parent and is not included in the eligible unit, the eligible unit shall consist of the natural or adoptive parent and the eligible children.

1. The parent of the eligible children shall sign the application for AFDC- related Medicaid and fulfill all obligations contained therein.
2. The eligible unit's financial eligibility shall be computed in accordance with N.J.A.C. 10:69-10.3(c). The countable income of the stepparent to the eligible unit, as determined in (d) below, shall be deducted as a countable income source.

(d) When a stepparent of eligible AFDC-C-related Medicaid program children lives in the same home as the children, has married the AFDC-C-related Medicaid program beneficiary parent, and is not included as a member of the eligible family, his or her income shall be considered available to the eligible family in accordance with the following procedures:

1. Reduce the stepparent's gross earned income (and net income from self-employment) by $90.00;
2. Add the result to the stepparent's unearned income;
3. Further reduce the remaining income by the appropriate amount in the standard of need (N.J.A.C. 10:69-10.2) for the stepparent and any other individuals residing in the

household who are or could be claimed by the stepparent as dependents for Federal personal income tax liability and who are not beneficiaries of AFDC-C, -F or -N related Medicaid program;

4. The remaining income shall be further reduced by amounts paid by the stepparent to individuals not living in the household who are or could be claimed by him or her as dependents for purposes of determining his or her Federal personal income tax liability;

5. Any income remaining shall be reduced by any amounts paid by the stepparent as alimony or child support to individuals not living in the household; and

6. All income remaining shall be counted as unearned income available to the eligible unit and shall be counted toward total income (N.J.A.C. 10:69- 10.3(a)).

10:69-10.34 (Reserved)

10:69-10.35 Procedures for AFDC-C and -F related Medicaid eligibility

(a) A child not meeting AFDC-related Medicaid age requirements but who is under age 21, may be eligible for Medicaid Special if he or she would be otherwise eligible for AFDC-C or -F except for age (see N.J.A.C. 10:69-4).

(b) Medicaid eligibility does not exist in cases where, after excluding the child(ren) whose income caused ineligibility for AFDC-related Medicaid, there is no child remaining in the eligible family.

(c) Any family whose eligibility is denied or terminated as a result of deeming of a sibling's or stepparent's income shall have its AFDC-related Medicaid eligibility evaluated without regard to that individual's needs or income.

10:69-10.36 Companion cases

(a) An eligible unit may include some members eligible for AFDC-C-related Medicaid and others eligible for AFDC-F or AFDC-N-related Medicaid. These combinations are called companion cases.

(b) Companion cases shall have a common case number.

(c) The AFDC-related Medicaid eligibility income standard for each related Medicaid program shall be the income eligibility standard for the total eligible unit at N.J.A.C. 10:69-10.4, as appropriate.

10:69-10.37 Calculation of contract earning income

Earnings payable under the terms of a renewable contract, for example, earnings of school teachers, are to be prorated over the stated term of the contract only.

10:69-10.38 Calculation of earnings as lump sum payment

When a member of the eligible unit receives a lump sum payment for services rendered over a period of more than a month, any disregard of earned income is to be computed for each month in which such income was earned.

10:69-10.39 Calculation of contributions of legally responsible relatives

(a) The CBOSS shall determine what contribution, whether in cash or kind, the relative is currently contributing or is willing to contribute toward the support of the eligibility unit.

1. Only the amount of support, whether in cash or in kind, actually being received by the eligible unit shall be considered as available income.

(b) It shall be recognized that a person's obligation to support those relatives for whom he or she is legally responsible takes precedence over any voluntary preference on his or her part to support relatives or other persons for whom he or she is not legally responsible, except as provided in N.J.A.C. 10:69-10.40.

1. Responsibility of a person for the support of his or her own minor children takes priority over any obligations to contribute to support of any other dependent relatives.

(c) When a relative is legally responsible for all members of an eligible unit, this LRR's financial capacity to support shall be considered as a resource to the eligible unit as a whole.

1. When a relative is legally responsible for one or more, but not all member(s) of the eligible unit, the LRR's obligation to support in relation to need shall be the per capita share of the eligible unit's adjusted allowance for those persons for whom he or she is legally responsible.

2. When a relative is legally responsible for two or more persons who are not members of the same eligible unit, his or her capacity to support may be allocated according to the relative's wishes provided that the amount allocated to any one individual does not exceed that individual's share of the adjusted allowance.

(d) The eligible unit ceases to be eligible for AFDC-related Medicaid when the amount of the LRR's evaluated capacity to support equals or exceeds the income eligibility standards and this support is actually available to the eligible unit.

1. The amount of the LRR's contribution shall be recognized only when there is affirmative evidence that such amount or its equivalent in goods or services is in fact available to members of the eligible unit.

(e) Where it is determined that an LRR does not have a capacity to contribute to support, any cash contribution which he or she voluntarily makes on a regular basis is recognized as unearned income.

(f) The CBOSS IV-D unit shall determine the capacity of an absent parent to support

his or her dependent children.

10:69-10.40 Evaluating LRR's capacity to support

(a) The LRR's capacity to support shall be based on his or her total gross monthly income, including all income of whatever kind and from whatever source except as stated in this section.

(b) Income determination rules are as follows:

1. "Gross income" means income before deductions, or the net profit from a business, farm or profession before income and other personal taxes are deducted. "Net profit" is the total revenue less the cost of producing the revenue. Business deductions which are allowable for income tax purposes may be recognized as expenses of producing this revenue.

2. The average income for the most recent period of four months may be accepted as satisfactory evidence of the average for the last year, but the income record for the entire 12-month period may be considered if the individual so requests and makes the necessary information available.

3. When an LRR is receiving food or lodging or both as part of his or her income, the total gross income shall be determined as follows:

i. The gross cash payment plus the monetary value of the maintenance received as used by the employer for tax purposes (the employer's monetary evaluation for payment of Social Security and withholding taxes).

4. When an LRR has roomer-boarders living in the home, N.J.A.C. 10:69- 10.12(c) or 10.20 shall be used to determine the net income to the LRR from such roomers or roomer-boarders.

5. When an LRR, other than a natural or adoptive parent, is living in the home of an eligible unit and makes payment to the eligible unit toward household expenses, that payment shall be treated as income available to the eligible unit in accordance with N.J.A.C. 10:69-10.12(c), if extensive personal services are provided, or N.J.A.C. 10:69-4.12. Such payment does not otherwise affect the LRR's evaluated capacity, if any, to contribute to support.

6. When an LRR has an emancipated child living in the home, such child shall be considered as a roomer or roomer-boarder.

(c) Whenever an LRR or his or her dependents are the recipients of benefits, current or accrued, which are granted for and restricted to a specific purpose in accordance with the requirements of the law or contract under which they are provided, such as education, relocation, rehabilitation, medical care, and so forth, such benefits shall not be included in the income of the LRR for the purpose of computing his or her evaluated capacity to support.

(d) The following types of extraordinary expenses shall be considered in the manner

specified, as affecting the LRR's capacity to contribute to the support of the eligible unit:

1. When an LRR is supporting or making contributions to support (including judicial orders for support) of a parent, child, separated or divorced spouse who is not living in the home of the LRR, the actual amount of such contribution shall be subtracted from the LRR's gross monthly income. These persons shall not be included in the determination of the LRR's family size.

2. Where the average monthly cost of medical, dental, and other medical services exceeds the appropriate amount shown in the following schedule of medical expenses, the amount of the excess shall be subtracted from the LRR's gross monthly income:

LRR's family size	Monthly medical expenses
1	$45
2	60
3	75
4	90
5	100
6 or more	110

3. When an LRR, whether before or following the determination of his or her capacity to support, is required to incur debts due to catastrophic events over which the LRR had no control (for example: fire, or flood), other than medical, the verified monthly amount of payments necessary to liquidate these debts shall be subtracted from his/her gross monthly income.

i. Whenever an LRR has been determined not to have a capacity to support for a specified period in order to liquidate indebtedness due to catastrophic events, the agency shall reevaluate the LRR's capacity to support at the date set for full payment of the debt.

4. If the LRR is providing educational expenses for one or more of his or her dependents for whom free educational facilities are not available, such expenses shall be deducted from the LRR's gross monthly income as follows:

i. When the individual is being maintained in the LRR's home, subtract the verified cost of tuition, fees, books and transportation, prorated on a 12- month basis.

ii. When the individual is being maintained away from home, subtract the above items plus any cost of maintenance in excess of $1,075 per annum, prorated on a 12-month basis.

10:69-10.41 Determining amount of LRR support

(a) Two sets of standards provide the basis for evaluation of an LRR's capacity to contribute to the support of the eligible unit:

1. Schedule IV-Part A applies to any natural or adoptive parent of eligible AFDC-

related Medicaid children who is not a member of the eligible unit (exception: when a stepparent is providing a parent's needs). The monthly income standard is derived from the applicable income eligibility standard plus average medical costs and the standard allowance for expenses of employment.

2. Schedule IV-Part B applies to all other legally responsible relatives, including parents of adolescent parents not living in the same home as the adolescent parent, and is based on the U.S. Bureau of Labor Statistics' moderate standard of living.

(b) Family size of the LRR shall include the following persons, except those who are members of the eligible unit:

1. The LRR and any of his or her minor children who are living with the LRR;
2. The LRR's spouse who is living with him or her; and
3. Any relative of the LRR or of his or her spouse who is and has been customarily living in LRR's home and for whom the LRR or spouse is providing at least one half the support.

(c) When the LRR is married and both the LRR and his or her spouse have income, consider the LRR's income only, including in the family size only the LRR and his or her minor children (see (b) above).

1. When both persons are LRRs, consider their total income and include all persons identified in (b) above in the family size.

(d) The method for determining capacity to support is:

1. Determine the LRR's gross monthly income, including both earned and unearned income;
2. Deduct the verified amount of extraordinary expenses as identified in N.J.A.C. 10:69-10.39(d);
3. Compare this adjusted income with the applicable monthly income standard on Schedule IV, part A or part B as applicable;
4. When the LRR's adjusted income is less than the applicable standard on the schedule, no capacity to support exists;
5. When the LRR's adjusted income exceeds the applicable standard, the amount derived from Schedule V below shall be the evaluated contribution for support of the eligible unit;
6. The LRR's obligatory contribution shall not exceed the per capita share of the eligible unit's adjusted allowance for the person(s) for whom the LRR is liable.

Schedule IV
Monthly Income Standards

Part A

Parents of AFDC children	Family size	Part B All other LRRs
$405	1	$1120
540	2	1560
675	3	2010
740	4	2455
810	5	2825
875	6	3125
945	7	3420
1015	8	3720
plus $70	Each additional person	plus $300

Schedule V

Table for Establishing LRR's Contribution for Support

Determine the difference between the LRR's adjusted income and the applicable monthly income Standard on Schedule IV. In the table below, find the amount of this difference. The corresponding amount appropriate for the number of persons in the eligible unit for whom the LRR is responsible is the contribution to be made by the LRR.

	Persons for Whom LRR is Responsible				
Excess Income	1	2	3	4	5
$1-215	$65	$65	$65	$65	$65
216-325	65	65	65	65	85
326-435	65	65	85	110	110
436-540	65	110	110	130	150
541-650	85	130	150	175	195
651-760	110	150	175	195	240
761-865	130	175	215	240	280
866-975	150	215	260	280	325
976-1085	175	260	305	325	370
1086-1190	195	280	325	370	435
1191-1300	215	325	370	435	475
1301-1410	240	345	410	475	540
1411-1515	260	390	455	520	584
1516-1625	280	435	520	585	650
1626-1735	325	475	565	630	715
1736-1840	345	520	605	695	780
1841-1950	390	565	670	760	845
1951+	20 percent of adjusted	29 percent of adjusted	34 percent of adjusted	39 percent of adjusted	43 percent of adjusted

income income income income income

10:69-10.42 Acceptable forms of LRR support

(a) The LRR may fulfill his or her obligation to support the person or persons for whom he or she is responsible by contributing one or more of the following:

1. Cash;
2. Shelter and household needs; and/or
3. Any other item determined to be mutually satisfactory to the client and county board of social services for which equitable monetary value can be clearly established.

(b) When a contribution other than cash is substantial, regular, and reliable, the monetary value shall be deducted from the monthly amount of the LRR's capacity to support. Such contribution must be acceptable to the eligible unit, except when ordered by the courts.

(c) When an LRR who has a capacity to support is providing shelter and household needs, whether in his or her own home or elsewhere, and payment for such arrangement is neither made directly to the client nor stipulated by court order to be made in an identifiable cash amount to a third party, the monthly monetary values shall be recognized according to Schedule VI below, but shall not exceed the LRR's evaluated capacity.

Schedule VI
Shelter and Household Needs

Number in eligible unit for whom shelter is provided	Monthly monetary value
1	$100
2	110
3	120
4	130
5	140
6	150
7 or more	160

10:69-10.43 Eligibility of sponsored aliens and deeming of sponsor's income to a sponsored alien

(a) The income of an alien's sponsor shall be deemed to be unearned income of an alien applying for AFDC-related Medicaid. Deeming continues until the earlier of naturalization of the immigrant or the immigrant's being credited with 40 quarters of Social Security coverage. Such quarters do not include any quarters after December

31, 1996 in which the immigrant or the immigrant's spouse/parent on whose record the immigrant is credited with quarters receives Federal means tested benefits. For purposes of this section, a sponsor is an individual, a public or private agency or organization who executed a legally binding affidavit of support on behalf of an alien (who is not the child of the sponsor or the sponsor's spouse) as a condition of the alien's entry into the United States. No income shall be deemed from a sponsor who is (or whose spouse is) receiving AFDC-related Medicaid or SSI.

1. These deeming provisions do not apply to any alien who is:

i. Admitted as a conditional entrant refugee to the United States as a result of the application of the provision of section 203(a)(7) (in effect prior to April 1, 1980) of the Immigration and Nationality Act;

ii. Admitted as a refugee to the United States as a result of the application of the provisions of section 207(c) (in effect after March 31, 1980) of the Immigration and Nationality Act;

iii. Paroled into the United States as a refugee under section 212(d)(5) of the Immigration and Nationality Act;

iv. Granted political asylum by the Attorney General under section 208 of the Immigration and Nationality Act;

v. A Cuban or Haitian entrant as defined in section 501(e) of the Refugee Education Assistance Act of 1980 (Public Law 96-422);

vi. An Amerasian admitted under Section 584 of the Foreign Operation Appropriations Act beginning March 20, 1988; or

vii. Battered immigrants or those who would be indigent, defined as unable to obtain food or shelter without assistance, because their sponsors are not providing adequate support.

(b) The amount of income of a sponsor which shall be deemed to be the unearned income of an alien shall be determined as follows:

1. The sponsor's total monthly wages, salaries, and net earnings from self-employment (and that of his or her spouse if living with the sponsor) shall be reduced by 20 percent (not to exceed $175.00);

2. The amount determined in (b)1 above shall be added to the unearned income of the sponsor (and that of his or her spouse if living with the sponsor);

3. The amount determined in (b)2 above shall be reduced by the following:

i. The appropriate amount from the standard of need (N.J.A.C. 10:69-1.2) for the sponsor, spouse, and other persons residing in his or her household who are or could be claimed by the sponsor as dependents for determination of Federal personal income tax liability and who are not beneficiaries of AFDC- related Medicaid;

ii. Any amounts actually paid by the sponsor or sponsor's spouse to people not living in the household who are or could be claimed by them as dependents to determine their Federal personal income tax liability; and

iii. Actual payments of alimony or child support with respect to individuals not in the

household; and

4. The remaining amount shall be deemed to the alien and shall be counted as unearned income in the determination of eligibility and grant amount.

(c) In any case where a person is the sponsor of two or more aliens, the income of the sponsor (and the sponsor's spouse if living with the sponsor), to the extent the income would be deemed to any one of the aliens under the provisions of this section shall be equally divided among the sponsored aliens.

(d) For the period of alien sponsor deeming, the sponsored alien who is not exempt from deeming under (a)1 above shall provide the CBOSS with any information and documentation necessary to determine the income of the sponsor and the sponsor's spouse (if applicable and if living with the sponsor) that can be deemed available to the alien, and obtain any cooperation necessary from the sponsor.

1. If the alien's circumstances change during the deeming period such that the alien is no longer exempt from or subject to deeming in accordance with (a)1i through vi above, the CBOSS shall reflect the resulting change in unearned income in the eligibility determination.

2. A sponsored alien is ineligible in any month in which adequate information concerning the income and of the sponsor or sponsor's spouse (if living with the sponsor) is not provided.

3. Unsponsored family members are not ineligible if a sponsored alien fails to provide information concerning the sponsor or sponsor's spouse (if living with the sponsor). However, any income the unsponsored family members actually receive from the sponsor shall be reported and considered in determining their eligibility.

(e) Income which is deemed to an alien shall not be considered in determining the need of other unsponsored members of the alien's family except to the extent the income is actually available. The sponsor's obligatory contribution shall not exceed the per capita share of the eligible unit's adjusted allowance for the alien(s) for whom the sponsor is liable.

(f) Any individual sponsor of an alien, and the alien, shall be jointly and severally liable for any incorrectly paid AFDC-Medicaid benefits made to the alien during the alien sponsored deeming period that was caused by the sponsor's failure to provide correct information under the provisions of this section, except as provided in (f)1 below.

1. When a sponsor is found to have good cause or to be without fault for not providing information to the CBOSS, the sponsor shall not be held liable for a recovery of incorrectly paid benefits.

i. Good cause is defined as including, but not limited to, a language barrier, mental impairment of the sponsor, the information was thought to be correct by the sponsor, or the sponsor did not realize foreign assets must be reported.

2. Incorrectly paid benefits for which the alien or the sponsor and the alien are liable as described in (f) above shall be recovered in accordance with the provisions of N.J.A.C. 10:49-14.

10:69-10.44 Deeming income of parents of adolescent parents

(a) Pursuant to the Tax Reform Act of 1986 (P.L. 99-514), which clarifies certain amendments of the Deficit Reduction Act of 1984 (P.L. 98-369), an adolescent parent is an individual under the age of 18 and who is himself or herself a parent of a dependent child.

(b) When an adolescent parent lives in the same home as his or her own parent(s), the income of such parent(s) shall be considered available to the eligible family in accordance with the following procedures. These rules do not apply if the parent(s) receive(s) SSI or AFDC-related Medicaid or if the adolescent parent is categorically eligible for the AFDC-N related Medicaid program only.

1. The gross earned income (and net income from self-employment) of each employed parent shall be reduced by $90.00.

2. The result shall be added to the unearned income of the parent(s).

3. The remaining income shall be further reduced by the appropriate amount from the standard of need (N.J.A.C. 10:69-10.2) for the parent(s) and any other individuals residing in the household who are or could be claimed by the parent(s) as dependents for Federal personal income tax liability and who are not beneficiaries of TANF or AFDC-C, -F or -N-related Medicaid.

4. The remaining income shall be further reduced by amounts paid by the parent(s) to individuals not living in the household who are or could be claimed by him or her as dependents for purposes of determining his or her Federal personal income tax liability.

5. Any income remaining shall be reduced by any amounts paid by the parent(s) as alimony or child support to individuals not living in the household.

6. All income remaining shall be counted as unearned income available to the eligible unit and shall be counted toward total income (N.J.A.C. 10:69- 10.3) and in the determination of eligibility.

i. In the event the eligible family unit is determined financially ineligible for AFDC-related Medicaid program due to the inclusion of such deemed income, Medicaid eligibility for the dependent child(ren) of the adolescent parent shall be determined in accordance with (c) below.

(c) When a family is determined financially ineligible for AFDC-related Medicaid due to deeming of the income of the parent(s) of an adolescent parent in accordance with this section, the dependent child(ren) of the adolescent parent shall be or continue to be eligible for AFDC categorically-related Medicaid coverage as long as the family's countable income, excluding the deemed income of the parent(s) of the adolescent parent, is less than the AFDC eligibility standard set forth at N.J.A.C. 10:69-2.6,

Schedule II, as applicable for the family size. Eligibility, in such instances, would be limited to the dependent child(ren) of the adolescent parent; the adolescent parent, therefore, would remain ineligible for such Medicaid coverage.

(d) If the adolescent parent does not live in the same home as his or her parents, the legally responsible relative provisions of N.J.A.C. 10:69-3.31 apply, and Schedule IV-B of N.J.A.C. 10:69-10.41(a) shall apply.

END OF SUBCHAPTER 10

SUBCHAPTER 11. RESOURCES

10:69-11.1 Resources and eligibility

(a) Individuals seeking benefits under the provisions of this chapter shall be determined eligible or ineligible without regard to the value of the household unit's resources. The eligibility determination agency shall inquire about the household unit's resources only in order to establish income that may result from the household unit's resources.

1. For the purposes of this section, resources shall include, but not be limited to, stocks, bonds, certificates of deposit, savings accounts and checking accounts.

END OF SUBCHAPTER 11

SUBCHAPTER 12. PRESUMPTIVE ELIGIBLITY FOR AFDC-RELATED MEDICAID CHILDREN

10:69-12.1 Scope

This subchapter describes presumptive eligibility for children up to the age of 19 who otherwise meet the eligibility requirements for AFDC-related Medicaid or Medicaid Special. The presumptive eligibility determination makes it possible for a child or the children to be covered by AFDC-related Medicaid or Medicaid Special services from a Medicaid provider for a temporary period prior to application for AFDC-related Medicaid or Medicaid Special benefits and while an application for these benefits is being processed by the county board of social services.

10:69-12.2 Period of presumptive eligibility

(a) The period of presumptive eligibility shall begin on the date an approved presumptive eligibility entity determines that, based on information provided by the family or representative of the presumptive eligibility beneficiary, the child(ren) meet(s) the requirements and standards of this subchapter.

(b) The period of presumptive eligibility shall terminate:

1. On the date a determination of eligibility or ineligibility for AFDC- related Medicaid or Medicaid Special is made; or
2. If the child (if appropriate), the child's parent, guardian, caretaker relative, or sponsoring adult fails to file an application with the county board of social services, on the last day of the month subsequent to the month in which the child(ren) was determined presumptively eligible.

10:69-12.3 Requirements for presumptive eligibility determination entities

(a) A qualified presumptive eligibility entity shall be a New Jersey Medicaid provider and:

1. An acute care hospital;
2. A local health department; or
3. A Federally Qualified Health Center (FQHC).

(b) An entity shall apply to the Division of Medical Assistance and Health Services and shall be approved as a presumptive eligibility determination agency upon training of the entity by the Division of Medical Assistance and Health Services.

(c) The Division of Medical Assistance and Health Services shall monitor the presumptive eligibility determinations made by approved presumptive eligibility determination entities. If the review discloses a pattern of incorrect presumptive eligibility determinations or failure to adhere to requirements, the Division shall initiate

corrective action, including, but not limited to, consultation and training. Continued incorrect presumptive eligibility determinations or failure to adhere to procedural requirements shall result in the Division revoking approval for that entity to make presumptive eligibility determinations.

10:69-12.4 Presumptive eligibility processing performed by the presumptive eligibility determination entity

(a) From preliminary information provided by the child (if appropriate), a parent, guardian, caretaker relative or sponsoring adult, the qualified presumptive eligibility entity shall determine if the child meets the eligibility criteria of this subchapter. The qualified presumptive eligibility entity shall obtain sufficient information from the child (if appropriate), parent, guardian, caretaker relative, or sponsoring adult by having the child (if appropriate), parent, guardian, caretaker relative, or sponsoring adult to complete the certificate of presumptive eligibility. For purposes of the presumptive eligibility determination, the approved presumptive eligibility entity shall request from the child (if appropriate), parent, guardian, caretaker relative, or sponsoring adult only that information necessary to determine the child's presumptive eligibility or ineligibility. The approved presumptive eligibility determination entity shall make the determination of eligibility based solely on information obtained in the interview and shall not require any verification or documentation of the presumptive eligibility applicant's statements.

(b) For any child determined presumptively eligible, the approved presumptive eligibility determination entity shall:

1. Complete and sign the certificate of presumptive eligibility and forward the original of the certificate to the Division of Medical Assistance and Health Services within two working days of the date the presumptive eligibility determination was made;
2. Forward a copy of the completed certificate and a referral, if appropriate, to the county board of social services of the child's county of residence;
3. Inform the child (if appropriate), parent, guardian, caretaker relative, or sponsoring adult that they must contact the county board of social services in order to set up an appointment to complete the application process for AFDC-related Medicaid or Medicaid Special benefits;
4. Give the child (if the child has completed the application for presumptive eligibility), parent, guardian, caretaker relative, or sponsoring adult of the presumptively eligible child a copy of both the certificate and any referral; and
5. Advise the child (if the child has completed the application for presumptive eligibility), parent, guardian, caretaker relative or sponsoring adult of the presumptively eligible child, in writing, of the address and telephone number of the appropriate county board of social services.

(c) For any child for whom the approved presumptive eligibility determination entity is unable to determine presumptive eligibility, or who is ineligible under the criteria and

standards of this subchapter or any other Division rules which apply to children, the approved presumptive eligibility determination entity shall refer the child to the appropriate eligibility determination agency for evaluation of potential eligibility for any other Medicaid or NJ KidCare entitlement. The address and telephone number of the appropriate eligibility determination agency shall be provided, in writing, to the child (if appropriate), parent, guardian, caretaker relative or sponsoring adult of the child.

10:69-12.5 Presumptive eligibility processing performed by the Division of Medical Assistance and Health Services

(a) Upon receipt of a properly completed certificate from the approved presumptive eligibility determination entity, Division staff shall:

1. Assign a presumptive eligibility number;
2. Create an eligibility record on the Medicaid Eligibility File;
3. Issue a Medicaid Eligibility Identification Card; and
4. Notify the approved presumptive eligibility determination agency and the appropriate county board of social services of the presumptive eligibility identification number assigned to the beneficiary.

10:69-12.6 Presumptive eligibility processing performed by the county board of social services

(a) Upon receipt of the certificate of presumptive eligibility from the qualified presumptive eligibility determination entity, the county board of social services shall check the Medicaid, Medically Needy, and NJ KidCare Eligibility database for existing eligibility. If the child is receiving Medicaid or NJ KidCare benefits, no further action shall be required by the county board of social services.

(b) If the child is not currently receiving Medicaid or NJ KidCare benefits, the county board of social services shall, notwithstanding the application disposition standards in N.J.A.C. 10:69-2.1, arrive at a case disposition within the presumptive eligibility period.

1. If the time specified in N.J.A.C. 10:69-12.2(b)2 has elapsed without a determination being made by the county board of social services, the CBOSS shall notify the Division of Medical Assistance and Health Services of any such delay. The Division shall continue the child's presumptive eligibility until a final determination is made by the CBOSS.

i. The county board of social services shall also provide the individual applying on the child's behalf with written notification of the delay prior to the expiration of the presumptive eligibility period, of the specific reasons for the delay. See N.J.A.C. 10:69-12.8(b) for the requirements related to the applicant's rights to a fair hearing due to the delay.

(c) In the case of a presumptively eligible child who is determined ineligible for AFDC-related Medicaid or Medicaid Special within the presumptive eligibility period, the child's

eligibility shall terminate on the date of the eligibility determination. If the child is ineligible for AFDC-related Medicaid, Medicaid Special or any other Medicaid program, the county board of social services shall provide the applicant with a written notice of such denial and the reasons why, as set forth in N.J.A.C. 10:69-12.8. If appropriate, the county board of social services shall also refer the child to NJ KidCare for an application for benefits.

10:69-12.7 Responsibility of the applicant

The child (if appropriate), parent, guardian, or caretaker of a presumptively eligible child shall contact the county board of social services during the presumptive eligibility period so that a face-to-face interview can be scheduled. As part of the eligibility determination process for AFDC-related Medicaid or Medicaid Special, the parent, guardian, caretaker of a presumptively eligible child shall be interviewed by the county board of social services staff, complete any forms required as a part of the application process, and assist the county board of social services in securing evidence that verifies eligibility.

10:69-12.8 Notification and fair hearing rights

(a) For a presumptively eligible child who is subsequently determined ineligible for AFDC-related Medicaid benefits, Medicaid Special benefits, or any other Medicaid or NJ KidCare benefits program, the county board of social services:

1. Shall not be required to provide either timely or adequate notice to the beneficiary or applicant of the end of the presumptive eligibility period. The presumptively eligible beneficiary shall not have any right to a fair hearing based on the termination of presumptive eligibility; and
2. Shall provide the child (if appropriate), child's parent, guardian, or caretaker relative, as appropriate, a notice of denial of the child's AFDC- related Medicaid or Medicaid Special application in accordance with N.J.A.C. 10:69-2.15(c)3iii. The denied AFDC-related Medicaid or Medicaid Special applicant shall have the right to apply for a fair hearing in accordance with N.J.A.C. 10:69-6.2.

(b) For a presumptively eligible child whose eligibility for AFDC-related Medicaid or Medicaid Special has not yet been determined within the presumptive eligibility period, in accordance with N.J.A.C. 10:69-2.15, the county board of social services shall provide the child (if appropriate), parent, guardian, or caretaker relative of the presumptively eligible child with written notification prior to the expiration of the presumptive eligibility period, setting forth the specific reasons for the delay in the AFDC-related Medicaid or Medicaid Special application processing. The presumptively eligible beneficiary shall be entitled to a fair hearing based on the county board of social services failure to determine the child's AFDC-related Medicaid or Medicaid Special eligibility or ineligibility within the application processing period.

(c) A child denied presumptive eligibility by an approved presumptive eligibility

determination entity is not entitled to adequate notice of that determination nor entitled to a fair hearing on that action. The denial of presumptive eligibility shall not affect the child's (if appropriate), parent's, guardian's or caretaker relative's right to apply for AFDC-related Medicaid or Medicaid Special on behalf of the child and to receive a formal determination of eligibility or ineligibility relative to that determination.

10:69-12.9 Scope of services during the presumptive eligibility period

All AFDC-related Medicaid or Medicaid Special beneficiaries shall be entitled to receive fee-for-service during the presumptive eligibility period all the regular Medicaid services defined at N.J.A.C. 10:49-5.2.

10:69-12.10 Limitation on number of presumptive eligibility periods

All beneficiaries of presumptive eligibility for children who make an application for presumptive eligibility benefits for any Medicaid or NJ KidCare program shall be limited to one continuous presumptive eligibility period during the year, which shall be counted from the first day the applicant initially received presumptive eligibility.